# A GEOGRAPHY OF THE NEW PUBLIC HEALTH

by

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## Abstract

Using the example of a locality this thesis examines the key elements of the new public health from a geographic perspective. Three voluntary groups (based in the London Borough of Tower Hamlets) have been examined as a case study of expressions of the new public health. The thesis argues that the new public health is an urban social movement, which has expressions at the local level which vary. It is argued that this variance results from the key elements which inform and shape the new public health. They are the nature of the public health activities and initiatives carried out; the organisation and representation of the groups that make up the movement; and the knowledge and activities informed by sense of the place that the groups have.

The sense of place of the groups collectively, and the individuals within the groups, informs what public health activities and initiatives are implemented based on perceived need. The sense of place of the area is also the main mobilising factor for the agents who make up the public health groups and hence the new public health movement. The new public health movement is an urban social movement organised at a number of different geographical levels and in particular at the local and international levels.

In discussing and describing how the new public health is a social movement, the thesis contends that previous exploration of social movements has failed to examine the importance that place has to the organisation and shape that movements take. This thesis, through a geographic analysis, constructs a new framework for looking at urban social movements with an emphasis on place. It also outlines how an geographical analysis of the new public health can broaden the focus of current research within medical geography by examining health within the wider context of society.

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# CHAPTER 1

## A GEOGRAPHIC FRAMEWORK FOR PUBLIC HEALTH

This chapter introduces the main themes of the thesis in addition to outlining its structure. It begins with an explanation of the term public health and then moves on to briefly describe how the new public health evolved. The second section of this chapter introduces the idea of the new public health as a global urban social movement, which is one of the key themes of this thesis. This is followed by the third section which highlights another key theme of the thesis, namely the importance and relevance of place to the new public health. The fourth section brings together the key themes of place, urban social movements and public health to introduce their interrelationship. The final section of this chapter outlines the structure of the rest of the thesis.

'Public health' is, as the term suggests, concerned with the health of 'the public', as opposed to the health of specific individuals. Its main aims are to prolong and maintain healthy life and to prevent ill-health and disease. Public health practices have been in existence for hundreds of years through measures such as quarantine for those with infectious diseases. However, public health as a discipline involved with planning and policy for the improvement of the health of whole populations, was not really developed until the nineteenth century, when laws were introduced to improve the sanitary conditions and the general environment (Brockington 1979). During the twentieth century, as medical technology developed, the focus of attention to improve health has moved away from treating populations (public health) to treating individuals (medical intervention).

The 'new' public health is a term used to describe the recent changes that have taken place, changes that have re-stated the importance and relevance that public health has to wider society, in terms of the policies that have an effect on the public's health; the occupations that

affect the public's health; the education, environment, housing, and sanitation that affect the public's health. It is precisely these associations that the new public health has to a wide variety of aspects of our lives, lifestyle, and environment that calls for an exploration of the new public health from within a geographic perspective, and it is this aim that this thesis addresses.

In the dictionary of Human Geography, Haggett defines geography as "the study of the earth's surface as the space within which the human population lives" and human geography as "a geography of the man made world" (Haggett in Johnston et al 1986 p175). Under such definitions it is easy to see why the study of public health is an ideal research topic for geographic inquiry. Public health encompasses the habitat that people have constructed as well as the natural or physical environment; public health addresses the relationship between people, their environment, and their health - a relationship that calls for a geographic framework of understanding.

As geography has developed over the last century, a number of sub-divisions have arisen within the discipline (Johnston 1991b), one of these has been the development of medical geography. It is within this sub-discipline that the analysis of public health from within a geographic framework has historically taken place. The previous emphasis on public health within medical geography has been concentrated on particular aspects of public health activity, such as the utilisation of health resources by populations, or the spread of diseases (Jones and Moon 1987) rather than an analysis of public health in its entirety. The focus of medical geography is discussed further in chapter four. The point to be established here is that public health is an ideal subject to be examined from a geographic perspective, but that previous attention within geography has focussed on particular elements of public health which have lent themselves to geographic inquiry, particularly in the form of quantitative methods. The purpose of this thesis is to use a geographic framework to analyse public health in its present form (the new public health), and to explore public health using a qualitative methodology.

## 1. The Re-emergence of Public Health - The New Public Health

The new public health has developed primarily through the World Health Organisation's (WHO) approach to health. WHO helped shape the re-emergence of public health as the fundamental objective of health development and changed the emphasis of health from the absence of disease towards the totality of well-being. The World Health Organisation's definition of health is "Complete physical, social and mental well being and not merely the absence of disease or infirmity" (WHO 1985). This definition was advanced in 1948 and was an important step in the development of a more holistic approach to health, at the time it was seen as a totally new concept. Yet, this approach of treating health in an holistic manner and the concepts that surround the new public health, are in fact not new at all, but are elements of the public health care that was developed in the nineteenth century - the old public health.

During the twentieth century technical advances in medicine and health care and the creation of the National Health Service in the 1940s led to public health moving away from a 'holistic' towards an 'individualistic' approach. This transition is discussed in detail in chapter two. The re-emergence of the 'new public health' in the last two decades is actually a revitalisation or renewal of the old public health developed over a century ago. It is the result of a realisation that in order to reduce inequalities in health between different populations, and individuals within populations, the emphasis has to be on health care and health services as a whole for the whole community and not solely on the individual (Ashton 1990). It has to be an approach to health, that encompasses everything from housing and environment to education and occupation, as it is only through this comprehensive approach that health inequalities will be reduced, and the whole of the population's health will be improved.

The World Health Organisation went on from creating a new definition of health in 1948 to re-defining and promoting concepts such as Primary Health Care (Alma-Ata Declaration) and Health Promotion (The Ottawa Charter), it later progressed to building programmes and initiatives to create and support healthy lifestyles and improve the physical, social and

economic environment (Health For All 2000 and Healthy Cities) based on the concepts it had developed. These initiatives are discussed in more detail in the next chapter.

The evolution of the new public health has to be examined in conjunction with the initiatives of the World Health Organisation, because their development was parallel and intertwined. More recently the new public health has been able to take on a more diverse role, and has fostered a critical element that does not exist within the World Health Organisation initiatives. This has been done through the creation of organisations such as the Public Health Alliance and Radical Statistics Health Group. However it is the actions of WHO that have helped to spread the interest and participation in the new public health. These initiatives through WHO have grown significantly and are now operating at the global level, across different cultures, religions, health care systems and governments. It is the global diversity and global magnitude of the new public health movement that makes it (especially appropriate and necessary) to examine it from within a geographical framework, as geography is one of the few disciplines geared to this type of cross-cultural comparison on a global scale.

In addition, the focus of the new public health is on the redistribution and more rational allocation of 'health' through space, which is attempted by reducing inequalities using a multi-sectoral approach, and addressing the needs of whole populations instead of individuals. Geographers have long been concerned with the distribution of resources through space, public health is not only concerned with the distribution and allocation of resources through space, but is concerned with the distribution of 'health' itself. The purpose of the new public health is to ensure that people's access to a better level of health is uniform and that ultimately environmental, economic and social factors will be compensated for so that health is not dependent on where you live. In this thesis the issue of access to better health will be examined within one particular geographical area. The analysis will focus on what 'public health' basis the decisions on where to concentrate resources and activities are made, and whether the decisions made are equitable.

Not all initiatives from within the new public health have occurred as a direct result of W.H.O. policies and strategies, but the fact that the new public health is gaining pace in all continents of the earth, enables us to see its significance to the health status of the world population, in addition to the world economy. Health is one of the basic pre-requisites of a productive population, and thus the health of a nation is essential to the nation's economy, and standard of living (Mahler 1981). Because the new public health is woven into so many aspects of society, such as education, housing, policy, and economy (Bremke 1990), the cumulative global effect is potentially enormous. A geographic framework of analysis has access to the appropriate methodology to evaluate and examine this potential global impact. Because of resource limitations in this thesis, in order to address the issue of the global impact of the new public health, a detailed examination of public health activities in one locality is used as a case study for wider generalisation. The merits and difficulties of using a case study as a model for theory development are discussed in the fourth chapter.

## 2. A Global Movement

The new public health, and initiatives such as the Healthy Cities initiative or Health for All 2000, represent a public health movement, and because of its world-wide existence, it is a global movement. There have been other social movements in the past that have operated at a global level, such as the Civil Rights movement, the Women's movement, the Anti-War movement and the Green movement. These movements can be considered global in that they were movements that occurred in a number countries throughout the world. Each of these movements has had their own characteristics and approaches which have differentiated them from one another; even within the same movement there are differences between how the movement expresses itself from one country to another. What is so important about the new public health movement is that, as a movement, it has the potential to be bigger than any of the previous social movements operating at an international or global level, in that health touches

on so many aspects of life. All the previous movements had elements that were part of public health, for example issues of inequalities, of environment, and of rights for minority groups are all aspects of health, when health is seen in the light of the WHO definition of complete "physical, social and mental well-being". Within this thesis one of the key themes is examining the new public health as a social movement, in order to understand the development and evolution of the new public health, and to allow cross cultural comparison of the new public health at a global level. Using urban social movements to analyse the new public health provides a framework within which the development, organisation and structure of the new public health can be examined. In addition the framework also provides a route to understanding the potential impact of the new public health on the economic, social and political systems.

Although the new public health is a global movement, it is shaped differently in different localities. These differences are dependent on the nature of the public health activities being undertaken by the local groups, and the particularities of the locality or place. Place is important both in objective terms (size, population, social and economic forces) and subjective terms (how the place is perceived by those working in public health and by the community that lives there). Thus although the overall objectives of the global movement - to improve physical, mental and social well-being - are the same, in practice different ways of achieving this objectives are dependent on the local situation. Thus an analysis of the new public health movement must take into account differences in organisation, structure, and perception of place at the local level.

A further reason to concentrate the focus of the analysis in this thesis at the local level, are that there are some important differences to the new public health movement, compared with other social movements. These include the fact that the new public health could be seen by some writers on urban social movements to be run centrally from within the bureaucracy of the United Nations through WHO, and therefore might not be a true social movement as it could be considered to be part of the organisation of WHO, and not a grassroots organisation.

Having a grassroots organisation is considered one of the main pre-requisites in defining an urban social movement (this issue is discussed in chapter 6). However, most of the activities involved in the new public health movement are at a very local level, most of them take no direct guidance from WHO other than being aware of its existence and the information it produces. As a social movement, the new public health operates at the global level, the national and regional levels, but its most important level of operation is at the most local level of the neighbourhood.

In Britain unlike other countries such as the Netherlands, Denmark, Australia or Canada, there has been very little national organisation of the new public health movement. (Tsouros 1991). However, since the period of research of this thesis the British Government has developed a national strategy for public health[1]. This strategy has received criticism as to whether is really does address public health issues, and indeed if the method of addressing these issues is within the new public health framework. This document and its criticisms are discussed in the final chapter of this thesis. In order to accommodate the observed structure of the new public health movement in this country (as a global and local movement with little national organisation) existing theories of social movements are developed in this thesis.

A further reason why the new public health is different from other social movements is that the aim of the movement is to improve the health of the people, by acting in a pro-active way, rather than being re-active to a situation or policy in the way that movements such as the anti-war, and welfare rights movements are. The new public health movement can easily be distinguished from a protest movement, unlike many other social movements. This is because of the positive emphasis towards action that is central to the new public health, and a further component to be incorporated into a new model of urban social movements developed in this thesis. The action or activities of the new public health differs greatly in different

[1] In 1992 the Government produced a White paper called "The Health of the Nation" designed to take a broad approach towards public health within the new public health approach.

the whole purpose is to direct activities to the specific needs of the population being served. Therefore a better idea of the intricacies and involvement of the new public health can be gleaned from an analysis at the local level.

It has been taken for granted by many writers that the new public health is an social movement (Kickbusch 1990b, Tsouros 1991, Ashton and Seymour 1988), but there has been little attention paid as to what makes the new public health an urban social movement, in the way that the detail of the movement is examined in this thesis. There has been no clear examination of the new public health movement within the context of the urban social movement literature, and there has been discussion as to whether health promotion is part of the new public health, an alternative term of reference, or a separate social movement (this is discussed in chapter two). For some the new public health is not a social movement in its own right, but utilises other social movements in order to achieve its aims:

> "The attainment of better health requires political action. It also requires that people constantly re-assert their health needs through social movements and wide participation." (Kickbusch 1990b p381)

This thesis sets out to demonstrate that the new public health does not utilise other urban social movements, but is an urban social movement in itself. It also seeks to demonstrate the operational levels of the movement (local and global), and the key factors that enable it to be defined as a movement, by developing and examining the new public health within the context of the literature on social movements. Although there has been little analysis of the new public health in relation to literature on urban social movements, in the recent literature on health promotion there has been criticism as to whether this area can be considered as a social movement. Because of the confusion as to whether health promotion and the new public health are synonymous, or whether health promotion is merely an element of the new public health, it is important to examine these criticisms.

> "Insofar as it has sought epistomological legitimation for its alternative knowledge of health and its appeals for new policy projects, the health promotion movement has tended to be preoccupied with a search for indicators .....which invites a recapitulation of essentially positivist logics" (Stevenson and Burke 1991 p 484)

The definition of health promotion used by Stevenson and Burke refers to the WHO concept of health promotion, which is intertwined with the key concepts of public health, and this is part of the confusion as to the part that health promotion plays in the new public health. Thus their argument could also be seen to be against the new public health movement. However, in answer to their criticisms it is arguable that it has not been the health promotion and public health movements that have been preoccupied with indicators, but rather the researchers of these movements, in attempting to evaluate the progress of the movements in a positivist tradition. This criticism enables us to see the value of a geographic framework of inquiry, that is able to look at public health and health promotion in the context in which they occur. A geographic emphasis also permits research into the value of the movement within a framework that suits the theoretical basis of the movement. In addition, a geography of the new public health has the ability to examine the issues at a variety of geographic scales, and using a variety of methodologies. Milio in her 1990 paper on *Healthy Cities and the New Public Health* calls for a research agenda for the new public health:

> "At the present early stage of policy making process research, whether undertaken at national or local level, detailed preferably comparable case studies are useful. These call for qualitative methods." (Milio 1990 p 294)

This is one of the main reasons for adopting a qualitative geographical framework in which to examine the new public health movement.

## 3. Environment and Health

The second important theme of this thesis in examining the new public health from within a geographic framework is in terms of the relationship it has to the environment. Environment is perhaps the most important factor influencing the public's health. If we examine environment in the same terms that the World Health Organisation defined health, as physical, social and mental environment, we can see the importance of environment as the main factor influencing public health. Physical, social and mental environment, can best be conceptualised and particularised through the notion of place, as these three elements of the environment are fused in particular places, and at the same time are the main constituents that make places differ. Our 'sense of place' is our interpretation of the physical, social and psychological characteristics of our environment. Thus when examining the new public health as a movement, its symbiotic relationship to environment cannot be overlooked, and indeed, is crucial to our exploration and understanding of the new public health.

It is this relationship to the environment which makes the new public health an ideal subject to explore from within a geographic framework. The implications of understanding this relationship fully are the key to understanding the new public health. If the way that public health activities are carried out, and decisions are made, depends on how the environment is experienced in physical, social and psychological terms, then an analysis of the importance of environment will have applicability to all areas of public health research. As outlined earlier in this chapter, if the new public health truly is a global social movement, than its potential impact on global processes is quite phenomenal, as improving health has implications for changes in the economies and societies of all countries of the world. If public health decisions are made on the subjective sense of place in conjunction with more objective factors, than understanding this relationship between the perception of the physical, social and economic environment and public health is crucial to understanding the development and impact of the new public health movement globally. This thesis sets out to develop a methodology for examining the importance of sense of place within the context of the new

public health, and to demonstrate the relationship between sense of place and the mobilisation and sustainment of urban social movements.

## 4. Social Movements, Place, and the New Public Health

In the literature on social movements (reviewed in chapter three), very little attention has been directed towards the concept of place. This thesis argues that in examining the new public health, place in terms of the specificities of the local population, their environmental and health needs, and their perception of the physical, social, and mental environment through sense of place, are integral to the analysis. It is the differences that occur at the local level that shape the form of the social movement. Each movement draws its members from the local community, and it is they who determine the needs to be addressed, and the action that needs to be implemented. This needs assessment and the activities carried out, are based on the experience and knowledge that the members have of the local place or environment. Thus in chapter three, it is argued that an analysis of a social movement must take account of place, and that new models of urban social movements need to be developed by geographers, in order that the importance of place can be highlighted and integrated into existing theories.

Further reasons for looking at the relationship between, public health and place, is that the new public health is inextricably linked to the environment, because public health is the only provision for health that has a spatial element. Firstly public health provides for populations not individuals and distributes its resources and activities through space to meet that populations needs, rather than providing them at a central point. Secondly, the public's health is determined by the physical, social and economic environment in which they live.

A geographic framework is used to look at the new public health in order to determine its role as an social movement, and to assess the impact and importance of the environment. However, the main value of a geographic framework lies in the ability it has to examine the

intricacies of the relationship between public health, the environment, and social movements. A geographic analysis is also able to determine the relative importance and relationship of these elements to each other in the continued and sustained growth of the new public health. This is the central theme of the thesis; an exploration of these three important elements of the new public health, and their relative contribution.

## 5. The Research Agenda

As previously stated, the new public health as a movement is organised at various levels, but is most prominent at the international or global level and at the local level. The process of organisation of the new public health at the local level has mainly been undertaken through the process of community development, where individual agents have mobilised local communities into actively participating in the new public health movement, primarily in the form of groups working on issues that affect them in their own community.

Because the new public health is primarily an activity that has been shaped at this local level, by individual agents and groups through the process of community development, an in-depth analysis of the new public health in this thesis has concentrated on the local level. But, as a case study some of the conclusions and observations made during the course of the research have relevance for the new public health on a larger scale of organisation. The area chosen for this research was East London, one of the poorest areas in Britain in both social and economic terms[2]. It is interesting to note that many of the first public health reforms

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[2] Indices of deprivation such as the Jarman Underprivileged Areas Index (Jarman 1983, 1984), and Townsend's Social Indicators score (Townsend 1982) and Department of the Environment indicators of urban deprivation (1983), all show the London Borough of Tower Hamlets to be one of the most deprived areas in Britain.

initiated in the nineteenth century were also directed at this part of London. (Holland et al 1985).

The research has concentrated on the analysis of the public health activities of three groups working in the East London Borough of Tower Hamlets[3]. The three groups are all working at different geographical levels within the borough - at the ward, neighbourhood[4], and borough level. The themes of community development, social movements and sense of place are all examined from within the context of the activities of these three groups. In order to develop the central theme of the thesis - an exploration of the main components of the new public health from within a geographic framework - much of the analysis is focussed on examining the groups' activities and public health practice. This is done through an evaluation of the way each of the groups works, and a comparison of similarities and differences between each group.

The thesis is divided into seven chapters. This chapter has introduced the themes of the thesis, and the predominant subject area. Chapter two sets the background and context of public health in England by tracing its changes and developments over time. The essential components and statutory obligations of public health are described, but most importantly the chapter focuses on the key themes of the new public health movement. These themes provide the context for the work carried out by the three groups being studied for this thesis, and also these themes are crucial to our understanding of how the new public health can be defined as an urban social movement, and how public health is inextricably linked with the physical, social and economic environment.

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[3] The three groups are The Tower Hamlets Health Strategy group, The Globe Town Health Action Area, and the Spitalfields Working Party.

[4] Tower Hamlets borough has been decentralised by the Local Authority into seven neighbourhood centres of local government administration.

The chapter begins by presenting an account of the history of public health in the mid nineteenth century, and demonstrates how the new public health is very much related to the public health activities of the Victorian period. The development of public health in the twentieth century is then outlined, and it is argued that public health in the twentieth century has become medicalised. This process of medicalisation started with the creation of the National Health Service whereby public health responsibilities were gradually removed from the local authority and made part of health service provision thus removing the close collaboration between local authorities and health authorities. Public health was further 'medicalised' as Departments of Community Medicine took over the control of public health, but with a primary focus on the control of infection and an orientation towards individuals rather than populations. In addition, Departments of Community Medicine organised themselves along the lines of other medical departments within hospitals, and further detached themselves from the communities they were working for.

The chapter then moves onto analyse the shift in approach to public health in the late 1980s both in the statutory and non-statutory sectors and how this change led to the creation of the new public health movement. The statutory obligations of Departments of Public Health (renamed from the old Departments of Community Medicine), and the Acheson report into Public Health in England are also reviewed. The essential elements of the new public health are then described, and are related to the development of the new public health through the initiatives of the World Health Organisation. The chapter then moves on to outline the development of the HFA 2000 and Healthy Cities initiatives, and explores the relationship of public health to health promotion by examining the Ottawa charter.

The third chapter deals with the theoretical considerations and discussions in the literature on 'urban social movements' and 'place'. After recounting the major contributions to the literature on these topics, they are related to the new public health movement, and are developed to incorporate the new public health within their frameworks. A critical perspective is also introduced, in order to highlight an area which has been ignored by previous authors

writing on urban social movements, namely an analysis of a movement simultaneously organised at the international and local level. Movements such as the Women's movement, Green Movement or Anti-War movement could have been analysed in this way as all have local and international organisation, however no attention has been paid to this in the literature, and in particular there is little reference to the reasons why movements differ at the local level of organisation. A discussion on the way that urban social movement literature has underplayed the value and contribution of place to the formation and organisation of movements is also part of this critical review. At the end of the section on the literature on urban social movements a new interpretation of the main constituents of an urban social movement are developed by this author.

The second part of chapter three analyses the development of research on place within geography from an historical perspective. The main focus is on the development of the concept of sense of place, and how this has been used. In the early 1980s a number of criticisms were made of sense of place studies, mainly relating to the inadequacy of the applicability of this concept. It was considered highly theoretical with no practical applications. These criticisms are analysed and a discussion of how they have been overcome in this research concludes this section. The research for this thesis has developed the practical application of sense of place by the use of projective techniques, and the concept of sense of place is closely integrated into the main body of research by demonstrating how sense of place is an integral part of urban social movement formation and public health activities. The emphasis on place within this thesis also relates to the current discussions within geographical discourse as to the importance of place as the central uniting theme of geography's sub-disciplines, and the essential element that differentiates human geography from other social sciences. The chapter concludes by recounting the main themes of the urban social movement and place literatures and how they relate to the new public health.

Chapter four outlines the methodological approach and methods used in the collection of the data used in the empirical work in chapters five, six and seven. An overview of the

research topics of medical geography is discussed, including their position with respect to other geographical sub-disciplines and research. The approach that is supported in this thesis is one of looking at health from within the totality of society, this approach has been hailed as the way forward for medical geography which has tended to examine health and health services away from the context in which they occur. In order to examine public health in an holistic manner a qualitative methodology has been selected, drawing heavily on ethnography. This methodological approach is examined in the context of this research, including a discussion on the possible difficulties of using such an approach. The different research methods employed in the data collection for the thesis are described and problems encountered during the fieldwork are also discussed.

Chapter five begins with an overview of the area in which the research was carried out, highlighting the level of deprivation and poverty in Tower Hamlets using census material and social and economic indicators. The importance of this is to set the social and political context within which the groups are working as well as to facilitate a basic understanding of the structure of the localities and the geographic boundaries the groups are working in, which is crucial to understanding the analysis of sense of place in chapter seven. Chapter five also describes the organisation and formation of the three groups and the Department of Public Health, based on documented evidence. The main projects that the groups are working on are outlined, and the history of the groups formation and membership are described.

The chapter then analyses the organisation and formation of these groups by drawing on interview material and data collected from participant observation. The purpose of this chapter is to analyse the activities of these groups, their structure and organisation, in order to assess whether they are urban social movements in their own right, and/or part of the wider new public health movement. By analysing the membership, organisation, and activities of the groups the differences between the groups are established and analysed to see whether they are a product of the particular localities the groups work in, or because of the ways that

the groups are organised. This analysis and comparison is a central element in establishing what factors contribute towards the formation of urban social movements.

Chapter six further analyses the interview material in the context of the theories developed by this author, in chapter three, and other writers on urban social movements. Instead of concentrating on activities of the groups, their membership and organisation, the focus of the first section of this chapter is on the shared ideology of each of the groups. This information is particularly important in assessing how and in what ways the groups are part of the new public health movement, by seeing whether they have a similar view of public health to the aims of the new public health movement as outlined in chapter two.

The chapter then reviews the evidence as to how each of the groups might be considered an urban social movement on the basis of the different criteria analysed in chapters five and six, and in the context of the definitions and interpretations of what urban social movements are, as described in chapter three. In particular the groups are examined within the interpretation of an urban social movement developed by this author in chapter three of the thesis. The final section of the chapter looks at Healthy Cities and the new public health as global social movements, and relates this back to the literature and theories that have been developed in earlier parts of the thesis. A scale of operational activities of the various levels within the new public health movement is produced to summarise the geographical levels of the new public health movement.

In chapter seven the focus is on analysing how sense of place informs the groups' activities. This is done on both individual and group levels by analysing the data collected through the use of projective techniques exercises in addition to material from the interviews and participant observation. The focus is on how the groups use sense of place to define the areas that they work in, and also how they use sense of place to explain their existence in terms of expressed need, and to validate the activities that they are carrying out. The role of sense of place is also analysed in relation to the part it plays in mobilising participants in the

new public health movement, this is done through the analysis of the groups shared sense of place. Differences in sense of place are related to the activities and structure of the groups as analysed in chapter five. The chapter concludes by analysing the role of sense of place within the new public health movement by examining the relationship between sense of place, social movements and public health activities as key elements of the new public health movement.

In the final chapter, the conclusions drawn from chapters five, six and seven are distiled to produce a synthesis that explores the relationship of public health, social movements and place to the new public health movement. The relative importance of these elements is discussed, but more importantly their inter-relationships are examined. This is done within the context of public health as outlined in chapter two, the context of the theories on place and social movements as outlined in chapter three, and from the context of the particular methodological approach taken in this research as outlined in chapter four. The conclusion then moves on to analyse the way the new public health can be examined from within a geographic perspective, be recalling evidence presented in this thesis in order to expand the ideas stated earlier in this chapter on the need for a geographic approach to understanding public health. The chapter concludes by highlighting areas for further investigation and also discusses some recent developments that have occurred after the period of fieldwork for this thesis. The chapter ends by re-stating the importance of a geography of the new public health.

## CHAPTER 2

## PUBLIC HEALTH: ITS EVOLUTION AND ITS PRACTICE.

This chapter provides part of the necessary context for the empirical work. The chapter is divided into three main sections, each covering a specific area. The first section describes the history of public health in Britain since the 19th century and the functions of Departments of Community Medicine / Public Health up until the 1970s. Thus providing the context in which public health has developed and changed over the past century, before a more detailed examination of public health in recent decades.

The second section evaluates the changes that have taken place in public health in the 1980s and 1990s, and how these have become known as the new public health. This section outlines the responsibilities of departments of public health in light of recent changes enforced by the NHS reforms that took place in April 1991 (as a result of the white paper published in 1989), and the recommendations of the Acheson report 'Public Health in England' published in 1988. The third section describes the evolution of the World Health Organisation's Health For All by the Year 2000 initiative from the Alma-Ata declaration and Ottawa charter, and the related work of the WHO European Region, in terms of the Targets for Health for All, and the Healthy Cities Project.

### 1. The 'Old' Public Health in Britain.

There are many definitions of public health but the most widely accepted is "the science and art of preventing disease, prolonging life and promoting health through organised efforts of society" (Acheson 1988). This definition is based on that formulated by the World Health Organisation in 1952. In the past, the term public health has been mistakenly

narrowly interpreted and associated in particular with sanitary hygiene and epidemic disease control (Brockington 1979 ). This was particularly true of public health in the 19th Century. The definitions of public health and health in general are far broader now, including factors relating to physical, social and mental wellbeing, as well as the environment; not just the absence of disease. The history of public health can be traced back to the Industrial Revolution when, for the first time, public health as an organised system of health protection came into being (Brockington 1979). Until the nineteenth century, public health in Britain was mainly concerned with the control of infectious diseases. The nineteenth century saw public health beginning to focus its attentions on sanitation, the environment, pollution, and general health promotion and education.

It is Edwin Chadwick who is held up as the founding father of public health in the nineteenth century. The impetus behind Chadwick's sanitary movement was to reform the way of life of the poor so that they had the chance to remain economically active. This was not intended for the good of the people, to improve the quality of their lives, but to improve the quality of the economy and eliminate the wastefulness of early death from disease. In 1842 Chadwick published a report entitled "General Report on the Sanitary Conditions of the Labouring Population of Great Britain" (Brockington 1979 p6). As a result of this and subsequent reports the public health or sanitary movement under the leadership of Chadwick successfully pushed through legislation for the improvement of the sewer system and housing. Chadwick believed that diseases were carried through the air in smells, and he believed that the introduction of better ventilation and drainage would alleviate disease. It was as a direct result of this theory that the water closet was invented to replace the earth closet thus removing the air or smell faster (Holland et al 1985).

Public health has changed since the times of Chadwick, largely in accordance with increased medical knowledge about how diseases and infections are caused and spread, and the solutions required to tackle them. Environmental health knowledge has also increased, in terms of the technology needed to sanitise houses, eradicate pests, and control pollution.

It is important to remember that it is the improvements in public health and in particular environmental health measures such as sanitation, housing and water purification that have added years to the average life expectancy of men and women in this country, rather than progress made in general medicine (McKeown 1979). For example, life expectancy for some groups of the population has tripled in the last hundred years. Watkin quotes one of the Chadwick reports that in 1839 for the "district of Bethnal Green the average age of death for mechanics, servants, labourers and their families was 16 " (Watkin 1978, p55). By 1939 average life expectancy for males at birth in England was 63 years - an improvement of 47 years for those in Bethnal Green (Jones H 1985 p36).

By 1871 the whole question of public health was considered by a Royal Sanitary Commission. Under central guidance, the main responsibility for developments in public health lay with the local authorities, who became armed with increasing legislative powers for this purpose. The medical officers of health emerged as the local authorities' principal executives in health matters (Holland et al 1985). In 1919, all publicly funded health activities were brought together under the Ministry of Health Act, and the medical officer for health became the accountable manager for the provision of services which included: infectious disease hospitals, general hospitals, personal health services for mothers, babies and school children, and specific infectious diseases such as tuberculosis (Watkin 1978). Many of these services are what we would now term 'health services' as opposed to 'public health services', although there was no clear division or separation at this time. The ministry also had responsibility for the environment and housing, as well as the promotion of good health. After the creation of the National Health Service (up until the 1974 reorganisation), the medical officer for health remained accountable to local authorities and was responsible for non health authority services, e.g. environmental health, communicable disease control, health visiting, and the prevention of ill health (Abel-Smith 1964).

It was between World Wars One and Two that the notion of public health as a government funded public service was developed. This was mainly due to the effects of the

depression in the 1930s, where the numbers of unemployed rose considerably and thus the level of poverty and ill health rose also. Those people in formal employment, particularly civil servants, were covered by the 1911 national insurance act, but the inter war years highlighted those who were not (unskilled workers), as well as highlighting the inadequate hospital provision for the poor. These factors contributed to the Labour Party plans drawn up for a state organised medical service, which were finally implemented with the creation of the National Health Service in 1948 (Watkin 1978).

After the creation of the NHS, the medical officer for health remained with the local authority and was responsible after for the limited non-hospital, non-GP services that the local authority continued to provide (Pater 1981). The post was also responsible for environmental health, communicable disease control, the school health service, health visiting, community nursing and midwifery, the prevention of illness, care and aftercare, and some welfare services. Again the division between health and public health services was not as clearly defined as it is now; the medical officer for health was responsible for a variety of services both clinically orientated, community orientated, and public health orientated. The medical officer for health had a responsibility to be aware of all possible threats to the public health of the district, to write an annual report on the sanitary conditions and vital statistics of the area (Holland et al 1985). Within the hospital structure, regional hospital boards developed the position of Senior Administrative Medical Officers, who acted as chief medical officers and were responsible for advice on the planning of clinical services, capital planning, medical manpower planning, and medical personnel matters, this post was directly related to hospital provision and health services, and there was very little public health input, other than the post being a development of medical officers who were responsible for the public health functions.

Within health authorities, the Todd Report of 1968 was set up to look into medical education, and recommended that a new medical speciality should be set up. A new faculty (the faculty of community medicine) was created to oversee training and standards for the

speciality (Todd 1968). It was this that led to public health becoming known as community medicine, and the faculty and departments of community medicine within health authorities and districts were organised in much the same way as the more clinically orientated faculties and departments, with a lineage of registrars, consultants and specialists. It was envisaged that the role of the specialist in community medicine would bring back the function of advising on the health of the population that had been lost in the NHS Act of 1948. This was further strengthened by the recommendations of the 1972 Hunter report, set up to look at medical administration, that medical officers for health and their staff should be brought together within the same department as the specialists and other medical staff in departments of community medicine. The Hunter report also envisaged doctors working full time in health service administration, and this was one of the roles of the new community physicians (Hunter 1972). The main disadvantages of these changes were that the public health role of medical officers was considerably weakened, as they became more involved with management within health authorities, and provision of hospital services.

After the 1974 re-organisation of the health service, and the integration of the tripartite NHS, (whereby hospital and specialist services, the Family Practitioners Committees and personal health services where brought together under a single administrative structure); the close links that had developed between local authorities and public health were again weakened. The public health doctors or 'community medicine physicians' as they became known, reported back to and were accountable to the health authorities in which they worked (Brown 1979). These changes to health authorities' public health function meant that public health was moved out of the arena of political accountability and made into an issue of service provision and systems control, like the other services provided by health authorities. These changes remained in place until the recent legislation on public health following the Acheson report 1988, and the NHS reorganisation white paper in 1989. Thus public health has been moving away from environmental issues, health education and promotion, away from the traditional or old style public health.

## 2. The New Public Health.

The 1980s have seen a return to the old style or traditional public health in Britain. There are many factors that have contributed to the shift in emphasis for public health towards what is commonly termed as 'the new public health' but which is more accurately described as 'the new 'old' public health'. One of the main instigators of the return to the old style public health has been the World Health Organisation (WHO). WHO have tried to build on the strengths and achievements of the old style public health. As Ilona Kickbusch (1989) the former European regional officer for health promotion with WHO said "We have strived for precision and integration by taking the words 'health' and 'public' quite literally when speaking about the new public health". It has become clear to most people working around public health issues, like W.H.O., that not only is it possible to plan for health services, but also to set goals for health, to enable societies to move forward and enhance their health potential. This has primarily been done through the World Health Organisations 'Health For All' initiative, (discussed in more detail in the next section), but also by individual countries through national strategies; since the research period for this thesis, a national strategy for England has been implemented by the government white paper 'The Nations Health' published in July 1992[1].

Another of the major influences on the new public health came from the recommendations of a group set up in 1986 by the Secretary of State under the Chair of the Chief Medical Officer, Sir Donald Acheson, to look at the future of public health in England. The terms of reference set out for the group were "to consider the future of the public health function, including the control of disease and the speciality of community medicine" (Acheson 1988. p1). Results of the inquiry report were published in 1988 (at the beginning of the research

[1] The Health of the Nation is discussed in the concluding chapter of this thesis. The Health of the Nation was introduced after the field study period of this thesis.

period for this thesis), it's remit, within the current institutional framework, aimed to do three things:

- to improve the surveillance of the health of the population centrally and locally.
- to encourage policies which promote and maintain health
- to ensure that the means are available to evaluate existing health services.

The recommendations in the report of this group, ("Public Health in England") were accepted by the Government and a circular was issued to all Health Authorities in December 1988. The report stated that the Faculty and Departments of Community Medicine should now change their names to the Faculty and Departments of Public Health Medicine, based on the "considerable confusion, not only with the general public but also with organisations and fellow professionals that the term 'community' gives rise to" (Acheson 1988, p12). Departments were also told to:

- appoint a Director of Public Health (DPH)
- make arrangements for an Annual Report by the DPH on the health of the population
- make revised arrangements for prevention and control of communicable disease and infection
- collaborate with Local Authorities, Family Practitioner Committees (now called Family Health Services Authorities), and other relevant agencies.

The report stated that its objective was to shift public health to the centre stage of public policy, and that the recommendations were made with that aim in mind. The report had important consequences for the funding and status given to departments of public health, and thus for public health itself. From comments and observations made during the course of this research, it appears that public health was considered by many clinical doctors as a 'soft option' for practice after qualification, as no real patients were involved, and the job was more managerial, it was thought to be an area of specialty for those who were not good enough for clinical practice. Changes to the structure of the National Health Service in April

1991 (instituted after the research period of this thesis October 1988 to January 1991) have meant that Departments of Public Health now have a role in purchasing health services for their populations as well as monitoring the health needs of the local people, and a responsibility for purchasing and in some districts, providing health promotion. These increased powers and responsibilities are helping to move public health into the public arena, and are establishing the discipline as a fundamental service for the improvement of the population's health. This in turn means that the changes in public health, of increased responsibilities and recognition is contributing to the rise in the new public health movement. Doctors who work in public health now have much more power and authority than their clinical peers, as they have influence over financial decisions made, are involved in drawing up contracts for services, and are ultimately responsible for deciding what services to purchase for their populations. It is now possible for public health doctors to have control over which of their clinical peers' specialities remain, and which are made redundant. In practice this is unlikely, but the potential is there, and many clinicians are facing the fact that decisions are being made by their public health peers, who they had previously undervalued.

The new public health is still presently in a transitionary state, from concentrating its planning on medical models of disease and illness to truly planning for health promotion and the wellbeing of the population. The biggest change has been in attempting to set goals for policy action and not just goals to change individual behaviour. It is this key area of challenging policy formulation and strategy that enables us to consider the new public health in terms of a social movement. Kickbusch outlined the epistemological challenge to public health in her paper, she says that "Health is integrated in family and community life, it is dependent on the physical as much as on the socio-economic environment, it is constituted through the interaction of human biology and personal behaviour and is created within a totality of culture and biosphere." (Kickbusch 1989)

The key concepts of the new public health movement are public ownership, public responsibility and public accountability for health. In other words, the new public health has

to re-establish the links to political action and social reform that the old style public health had. For these reasons, there were a number of criticisms of the Acheson report in relation to the new public health, as it was felt that the report failed to address a lot of the needs of a new style public health, not least for more political accountability, criticisms against the Acheson report for having missed a valuable opportunity appeared in the British Medical Journal, (Phillips and Eykyn 1988, Ashton 1988, Nicholl 1988, Gabbay 1988) and a number of people (predominantly public health professionals/doctors) joined a new voluntary association, the Public Health Alliance. The Public Health Alliance is an independent voluntary group, formed in 1988, whose aim is to bring together individuals and organisations committed to promoting better public health. The Alliance placed great emphasis on moving the new public health into the political arena. In the Public Health Alliance's response to the Acheson report, they outline their principles of a new public health movement:

* Public protection and the prevention of ill-health should have priority over costly individual attention
* Publicly available information should be freely available in a democratic society
* Choice should operate equitably and justly
* Services should operate as closely as possible to the people affected by them, and should be fully accountable.
* Public health services should be returned to the status formerly held by them and expanded where appropriate.
* Britain should re-assert its former world lead in the development of public health measures.
* New services should be set up where needs have long been shown to be existing.

The Public Health Alliance are lobbying for these functions to be taken on by the government, who should, as signatories of the WHO Health For All 2000 initiative, be implementing such measures. The new public health movement argues that opportunities

for improving health are now at a stage where they have moved beyond the services that have been traditionally offered, with their emphasis on cure and care. The new public health is concerned with tackling all the root causes of avoidable illness, through methods ranging from specific legislative and fiscal interventions to the reduction of social class linked inequalities and the provision of education in its widest sense, (Laing and Taylor 1989), as Gish (1984) states:

> "Public health in its conventional forms, has been virtually gutted of its social and political content to the serious detriment of its theory, study and practice." (Gish 1984, p338)

Gish goes on to talk about the roles for a new public health worker, and highlights many of the ideas that Acheson had been criticised for not including. For example, public health workers becoming more involved with equal opportunities for use of health care, and more knowledge about the effects on health of all types of economic, social and political practices. And finally Gish concludes that

> "the recognition of wider forms of public health leadership should follow, coupled with organisational changes directed at the greater participation of popular groupings in all types of public health activities." (Gish 1984, p 338)

In other words, he was suggesting that public health activities need no longer be confined to public health-medical-professionals,[2] but can be taken on by voluntary groups, communities and individuals. In this respect the new public health is very different to the public health of the 19th century, where control of public health activities were very much in the hands of

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[2]People working within the voluntary sector around public health issues, can also be termed as public health professionals, and therefore the distinction is made between those are medically qualified and those not.

professionals; it is one of the key components of the new public health, that everyone can be involved from decision making to implementation.

As Ashton (1990) points out "what is emerging as the new public health is a synthesis of environmental and lifestyle change together with appropriate prevention and treatment interventions." The re-focus on environment has been particularly important in the new (old) public health. Turshen in her book *The Politics of Public Health* illustrates the differences between the more medicalised community medicine and the new focus of an environmental approach that the new public health should have.

> "we change the individuals reaction to stress rather than investigate the organization of work that is stressful; we educate workers to wear protective clothing, rather than re-design machines that emit hazardous substances; we alter individual eating habits, rather than restrain the food industry from supplying a diet high in polyunsaturated fats; .....and we campaign against smoking rather than stop subsidising the tobacco industry" (Turshen 1989 p55)

What Turshen is pointing out is that the new public health is moving away from blaming the victim, and observing health problems as social or societal rather than individual. However, it is also arguable that the role of the new public health is not just to implement policy changes, which cover economic, social and physical components, but it also has a role in bridging the gap between curative and preventative medicine. The idea is to focus on integrated systems for promoting and maintaining health rather than creating a division between disease prevention and treatment for illness and disease already contracted.

To summarise, the new public health is concerned with health at the macro level, its aim is to create policy changes which will affect the wider environment in which ill-health occurs, and to promote better health for all sections of the community, better access to

improved health and health services, and most importantly to help decisions about health to be taken at the level of wider society rather than at the individual, in an attempt to move away from victim blaming. The new public health has to have strong community roots, as its success is dependent upon its support from the ground, and the participation and action of the community. In order to influence policy, change decisions and practices, and create a more equal system of health provision and 'healthiness', the new public health movement has to combine forces with other groups, whose campaigns and issues touch on health, such as Trade Unions, Voluntary and Community Groups, Local Authorities, and Academics.

The most important role the new public health has to play is in the development of health promoting environments. Public health is inextricably linked with the environment, and the new public health is taking account of the physical, social, and economic environments and their effects on health. This is the basis of the new public health. It is because the new public health has such an important relationship to place, that this thesis aims to explore the new public health from within a geographic framework, in order that a fuller understanding of the importance of the element of place, and its relationship to public health activities and the organisation of the movement can be gained. It is the physical, social and economic environment, or places that people live in, that affect their health more than individual medical histories (McKeown 1979). Thus the challenge to the new public health is to develop a positive, growth promoting physical, social and economic environment, in which the public health can develop. In order to try and realise this goal, a number of approaches have been taken within the new public health framework, of which the most well known, and perhaps most successful, has been the Health For All 2000 initiative.

## 3. Health For All By The Year 2000.

In the mid 1970s the WHO decided to set up a formal programme of activity in order to take public health into the twenty-first century. The initiative is known as Health For All by

the Year 2000. In 1977, the World Health Assembly, (the central authority in WHO), decided that the main social target of WHO for the next few decades should be the "attainment by all the citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life" (Resolution WHA30. 43). Health For All is a holistic concept which embraces everything from agriculture, and industry, to education, housing and communications.

The Alma-Ata declaration

In 1978 the WHO convened a conference in Alma-Ata in the former USSR in order to look into how the aims of Health For All could be achieved. The conference concluded that the key to attaining health for all by the year 2000 would be through primary health care and economic and social reforms. The Alma-Ata conference stressed the point that health should be regarded as a key objective of economic development and not merely as one of the means of attaining it. At the end of the conference a declaration was made, which challenged all governments to work towards the attainment of Resolution WHA30.43 - Health for All by the Year 2000. The Alma-Ata declaration stated:

> "The conference strongly reaffirms that health, which is a state of complete physical, mental and social well being and not merely the absence of disease and infirmity, is a fundamental human right and that the attainment of the highest level of health is a most important world-wide social goal whose realisation requires the action of many other social and economic sectors in addition to the health sector."
> (WHO 1978, p5)

The Alma-Ata conference and declaration, in discussing how to implement Health For All, realised that what was required were changes in emphasis in the provision of health care. These can be summarised into four main areas:

* From curing and treating illness to preventing illness and promoting health.
* From hospital-based care to primary care services based in integrated teams.
* From the health sector being the sole provider of services to multi-sectoral action.
* From professional dominance to community participation.

The Alma-Ata declaration played a significant role in shaping the development of the new public health and its focus on communities, primary health care, multi-sectoral action and participation by the community. The Alma-Ata declaration was one of the elements of strategy for the new public health. Another important development instigated by WHO that had an important effect on the re-emergence of public health and its strategy is the Ottawa Charter on health promotion.

## The Ottawa Charter

In 1986 a conference held in Ottawa in Canada on Health Promotion developed the principles of health promotion that WHO uses, and a charter was produced to lay these out (WHO et al 1986). Health promotion can be seen as an integral part of the new public health which plays a considerable and substantial role. The definition of health promotion used in this thesis is that health promotion is neither a discipline or a science, but an approach which incorporates disease prevention, health maintenance and health improvement. It draws on a number of different methods and methodologies, and concentrates its activities in the setting of everyday lives, and relies on community participation and a primary health care approach from

professionals (WHO 1984). However, the difference between health promotion and public health is that health promotion is one of the tools used for achieving better public health, but the new public health is the overall process which utilises health promotion as a tool amongst other tools. The new public health is also concerned with setting the aims and objectives, measuring the needs and defining the problems, and evaluating the impact of the various interventions or programmes it carries out. The new public health and health promotion, as advanced by WHO, have many similarities, particularly in terms of the components or themes that their work is based on. However, health promotion is much more limited in scope than the new public health, particularly in terms of making the links between action and policy.

The concept of health promotion that has emerged from the World Health Organisation has five main principles of a strategy for achieving health promotion. The first principle is concerned with 'building public policies which support health'. The importance of this principle lies in the fact that health promotion goes beyond health care and makes health an agenda item for policy makers in all areas of governmental and organisational action. It is the role of the new public health that requires that the obstacles to the adoption of health promoting policies be identified in non-medical sectors, together with ways of removing them, with the overall aim being to make the healthier choices the easier choices.

The second principle can be defined in terms of creating supportive environments. As was stressed in the Ottawa charter "health promotion recognises that both at the global level and at the local level human health is bound up with the way in which we treat nature and the environment" (WHO et al 1986). This principle can be more widely defined in terms of the role of the new public health: societies which exploit their environments without attention to ecology, reap the effects of that exploitation in ill-health and social problems. Health cannot be separated from other goals and changing patterns of life, work and leisure have a

definite impact on health. The new public health through the process of health promotion must create living and working conditions that are safe, stimulating, satisfying and enjoyable.

As in most models of health promotion the third principle of the Ottawa charter stated the need for community involvement. Health promotion works most effectively through community action. The significance of this for the new public health is that this is where the new public health mobilises the community to act for the new public health movement. At the heart of this process is communities having their own power to make and take decisions, having control of their own initiatives and activities. This means that professionals must learn new ways of working with individuals and communities - working for and with rather than on them; working as a team, together as part of the force for change.

The fourth principle of the charter was designed to develop personal skills. The idea being that health promotion should support personal and social development through providing information and education for health and by helping people to develop the skills which they need to make healthy choices. This enables people to exercise more control over their own health and over their environments. It makes it possible for people to grow and to develop throughout life, to prepare themselves for all of stages of life and also to develop the ability to cope with chronic illness and injuries. The new public health has widened this focus to encourage personal growth and development in all areas of life and not just those specifically related to health. The new public health also encourages activities to take place in a variety of settings: in school, home, work and in community settings, and not just health settings. By promoting empowerment, the new public health is using this principle as one of the main mechanisms for reducing inequalities in health.

Finally the charter recommended that health services should be reorientated. The responsibility of health promotion in health services should be shared among individuals, community groups, health professionals, medical care, bureaucracies and governments. They must work together towards a health care system and indeed, a social, economic and political system which contributes to the pursuit of health, in other words, stressing the need for multi-sectoral working and participation by the community - essential components of the new public health, and ideas that were developed in the WHO Health For All initiative.

Health For All and Healthy Cities

Both the Alma-Ata declaration and the Ottawa charter, although focussed on two specific areas (namely primary health care and health promotion), are intimately concerned with public health activities, and it was through these activities that action on Health for All by the Year 2000, and the Healthy Cities initiative (within the European Region) began, in an attempt to put many of the proposals from the declaration and charter into action. The European Region of WHO took some interesting and innovative steps towards achieving the overall goal of HFA 2000. The European Region of WHO formulated a common health policy, which involved setting up 38 targets to be achieved by the year 2000. Although the targets were drawn up two years before the Ottawa charter, the targets have been reviewed and were developed within a similar theoretical base to the points on the charter. The targets were based on a number of themes similar to those stressed in the Ottawa charter and Alma-Ata declaration. By 1986 the European Region of WHO noticed that much of the work that was being done towards HFA 2000 was concentrated in cities, and because of the increasing urbanisation of the region they decided to focus a second project towards achieving HFA 2000 specifically through promoting multi-sectoral action in cities - the Healthy Cities Project. Other WHO regions of the world are also working towards HFA 2000 and have implemented different strategies set out towards the attainment of the overall goal.

Following the adoption of the Health For All initiative as the main social target of governments and WHO, the European region formulated a common health policy in 1980 (Eur/RC30/R8 rev.2), which was developed into 38 specific targets in 1984. The development of the Health For All programme has emphasized the fact that the promotion of the public health requires more than the efforts of the statutory agencies which carry public health responsibilities. To quote the first chapter of "Targets for Health For All":

> "One principle is true for all countries: the key to solving many health problems lies outside the health sector or is in the hands of the people themselves. High priority should therefore be given to stimulating the contributions that other sectors and the public at large can make to health development, particularly at the local level. It is essential in this respect to accept the basic principle that people's involvement in health development cannot merely be passive. It is a basic tenet of the Health For All philosophy that people must be given the knowledge and influence to ensure that health developments in communities are made not only for, but also with and by the people. Primary health care is the most important single element in the re-orientation of the health care system and will require very strong support. It is also important to ensure more economical, effective and humane use of existing health care resources."
> (WHO 1985, Page 11)

The aim of Health For All by the year 2000 does not mean that by 2000 disease and disability will no longer exist. What it does mean is that resources for health will be evenly distributed and that essential health care will be accessible to everyone, with full community involvement. It means supporting people in realising their power to shape their own lives in the awareness that ill-health is not inevitable (WHO 1985 p16).

Despite the overall high level of development in the region and the scientific, economic and educational level of most countries, there still remain enormous inequalities in health (WHO 1985). The European region compiled a list of 38 targets set out in pursuit of attaining HFA 2000. In September 1984, all of the member states of WHO in Europe, including the UK, endorsed the WHO's 'targets' document, which set out the targets and gave suggestions for action. In order to ensure that the pledge would be followed by concrete action all member states agreed to submit a progress report every third year from 1985 onwards. As a result of the evaluation of the progress reports, in 1991 the targets were reviewed and modified, one of the main reasons was because of the low level of attainment by some countries within the European region (WHO 1992). Other targets were modified to be come more ambitious, for example, targets 6,7,and 8 were broadened to focus on population groups such as women, elderly people , children and young people. For targets that were supposed to be attained by 1990 or 1995 new target dates have been set (WHO 1992).

The original 38 targets endorsed by the WHO European Assembly can be divided into three categories:

- Main Health Objectives to be achieved by the year 2000 (Targets 1-12)
- Environmental and lifestyle improvements to be achieved by 1990, 1995, or 2000, (Targets 13-31)
- Policies and systems to be in place by 1990 (targets 32-38)

The regional targets were set down to encourage debate on national health policies and the formulation of Health For All strategies in the member states. The target levels are not based on elaborate mathematical models but on the historical trends, expected future evolution and the knowledge available on the probable effects of intervention. After the targets had been agreed upon, a set of regional health indicators was developed for use by each country in their report back to WHO

More important than the targets was the creation of six main themes around which strategies for achievement of the targets could be based:

Equity - Inequalities in health between countries and within countries should be reduced as far as possible.

Health Promotion - People should be given a positive sense of health so that they can make full use of their physical, mental and emotional capacities.

Community Participation - A well informed, well motivated actively involved community is needed in order to attain HFA

Multi-sectoral Collaboration - This is the only way to ensure the prerequisites for health are provided in all areas of life.

Primary Health Care - The need of the community should be met as close as possible to where people live and work.

International Cooperation - Some health problems transcend national frontiers e.g. pollution and therefore cooperation is needed to solve them.

The importance of the themes is that they are concerned with setting processes in place to achieve the targets, and improvements in health. After the establishment of targets, the Healthy Cities Project was started as one of the mechanisms for working towards Health For All. Healthy Cities came about as a result of a workshop held in Toronto in 1984, where the potential benefits of a city strategy for health were recognised, as well as the potential of applying concepts of HFA at the local level. One of the reasons for developing the Healthy Cities strategy was that most of the world's population live in cities (Kidron and Segal

1987), and health care and health status is often poorer in cities than in rural areas. This led to investigations by WHO and in Lisbon in 1986 the first European Healthy Cities were launched.

Knowledge and participation in Healthy Cities grew much wider than HFA as this initiative provided an effective vehicle for involving a much wider public in the Health For All processes and a high level of public visibility for WHO, the projects produced concrete examples of how to develop and apply Health For All. Although originally 11 project cities were selected, within a year this had grown to 25, now there are over 50 participating districts in England alone (Ashton et al 1986). Many national networks have grown up (Tsouros 1991). The main aim of Healthy Cities is to mobilise the energy and creativeness of local governments and the community and to harness their efforts towards achieving Health For All. Healthy Cities addresses two of the key principles of Health For All, namely multi-sectoral collaboration and public participation. The goal of the WHO Healthy Cities project is to enhance the health of cities, their environments and their people, and thus was one of the first major urban health projects (WHO 1989).

The aims of Healthy Cities are to:

- bring together a network of European cities to assist and support implementation of local Health for All efforts.
- develop a vision about health in cities, based on Health for All, health promotion and urban ecology;
- put health high on the political agenda of cities and contribute to the development of healthy municipal policies;
- put health high on the social agenda of cities, and thus to get health issues integrated into city life and city culture;
- foster the development of urban physical and social environments supportive of health based on a new approach to municipal environmental health policies and actions based, and recognising the close inter-relationship between social and physical environment;

- create action for and in public health that emphasizes the interaction between people, environments, lifestyles and health.

The Healthy Cities project as an element of Health For All 2000, begins to give an understanding of how the concepts behind the new public health that are advocated by groups such as the Public Health Alliance can be put into action. In order for the new public health to succeed there have to be mechanisms in place to achieve the objectives. The new public health is striving for more than just simply achieving the targets set down by the European region of WHO in the HFA 2000 initiative. It is the processes involved with projects like Healthy Cities and HFA 2000, striving for change at the political and policy levels, that have singled the new public health out as a force for radical change in health care and provision, in health maintenance and gain, and it is this change that leads us to examine the new public health as an urban social movement, with a variety of expressions at the local level. In the context of this thesis, the new public health has been studied in Tower Hamlets, East London.

This chapter has provided the context for the study, by outlining the main developments in public health since the mid nineteenth century, and highlighting the similarities between public health in the nineteenth century, and the new public health movement that has emerged during the 1980s. The similarities between these two periods of public health is that the focus for action is on the macro level: on communities and populations. This is unlike the individualistic approach taken from the turn of the century up to the 1980s, which tried to 'medicalise' public health by severing the ties that public health had with local authorities, education, occupation and housing, i.e. the ties that public health had with the physical, social and economic environment, which all health is affected by. The new public health recognises that improvements in health, and inequalities in health can only be resolved by looking at the health of communities in the context of their physical, social and economic environments, and by implementing policy changes that can alter these environments.

The new public health has had its strongest developments outside of the medical profession, and at a global level the implementation of its ideas can be seen in the World Health Organisation's initiatives such as Health For All 2000 and the Healthy Cities Project; and at the local level, by the work of voluntary groups, such as the groups that are studied in this thesis. There has been little national level organisation in this country around the new public health, apart from the Public Health Alliance, and other informal networks, such as the Environmental Health Officers Network, and the UK Healthy Cities Network. In order to analyse the new public health in more depth, this study concentrates on groups organised at the local level, and focuses on three groups in particular, based in the east London Borough of Tower Hamlets. The thesis examines to what extent these groups, through their activities around public health issues, are a local expression of a new public health urban social movement, one that is concentrating its activities on the physical, social and economic 'place' that affects health, and that is mobilised by the knowledge and perceived need of the environment derived from the sense of place. In order to develop further the theoretical context for examining these ideas, the next chapter looks at the literature surrounding urban social movements and place.

## CHAPTER 3

# SOCIAL MOVEMENTS AND PLACE: UNDERSTANDING THE THEORETICAL CONTEXT

The purpose of this chapter is to introduce the theoretical context of the research and to review the literature that has been written on urban social movements and sense of place. The chapter begins by discussing the development of the theory of social movements and then outlines the interpretation given by this author of what constitutes a social movement. The chapter then examines how much of the literature on social movements has underplayed the value of place in the structure and formulation of movements, before concluding by outlining the relevant literature on place studies, and sense of place.

The reasons for concentrating on urban social movement and sense of place, as previously discussed, centre on the importance placed on these areas as key elements of the new public health, and also as key geographical components, which can lead to an understanding of a geography of the new public health. Although sense of place and social movements are considered as two of the three key elements of the new public health in this thesis, there is also a strong relationship that exists between them as elements in their own right. This author believes and demonstrates in this thesis, through an analysis of the new public health movement, that social movements operate around the collective sense of place that movement members have. It is the perceived needs, experiences and activities of their locality that bring members together, especially in the urban context, to mobilise around a particular issue. In analysing urban social movements literature, it is apparent that little attention has been paid towards the role of place and sense of place in the formulation and maintenance of a movement.

In the case of the new public health movement this relationship is even more important because public health is intrinsically entwined with the physical, social and economic

environment. In order to explain a geography of the new public health the concepts of social movements and sense of place have been developed and reformulated to take account of the intricacies of the new public health movement, and have been restated in terms of their importance to one another. This chapter focuses on what has been written by other writers on these two components of the new public health movement.

## 1. Urban Social Movements - A Definition

In general the study of urban social or protest movements has been guided by a number of questions; why the movement came into being; how does the movement organise itself; and what is the significance or achievements of the movement. Writers on urban social movements have tended to concentrate on issues around housing, welfare and education. Health in the sense of public health has received little or no attention. Some writers have focussed on protest around the closure or merger of hospitals, and other specific health services, but not public health, the anomaly being that public health is the only true health service that can be collectively consumed - one of the criteria for status as an urban social movement that has been advocated by a number of writers (Castells 1977, Dunleavy 1980). Within this section the focus will be on social movements as opposed to protest movements. Some writers such as Lowe (1986) make no distinction between the two, however there are clear differences between what constitutes a protest movement and what constitutes a social movement. Protest movements are more reactive to the state and are more concerned with lobbying for changes in governmental service provision, whereas social movements are more concerned with changing some of the underlying structure within urban society, not just urban government. As Lofland (1985, p5) states "Protest movements are set off from others by virtue of being less permanent forms of collective action and being spontaneous, unplanned and episodic." The terminology surrounding the study or urban social movements and urban protest movements is not used in the same way by all writers. The lack of clarity means that comparing approaches to the study of movements can be difficult at times.

Since the 1960s urban social movements have been a common element in the cities of both developed and developing countries. Urban social movements cover a wide variety of issues and also span a wide range of goals. They have included organisations that have protested about a wide variety of issues including changes in land use, education, rent rises, inadequate housing, and gay rights (Eyerman and Jamison 1991). Some movements are concerned primarily with economic issues, such as housing, whilst others are more concerned with issues such as cultural identity. Some urban movements are intensely local affairs, concerning a street or particular building, whilst other movements concern national or international issues that impinge upon a particular neighbourhood (Scott 1990). Some social movements have a definite working class base, whilst others are dependent on middle class sources of power for their success, some groups are reactive whilst others are pro-active. And whilst most are defined as left wing or at least liberal-progressive, urban social movements are not defined by these conditions, they are not rooted in the class base of the membership which merely constitutes one element of their definition. Studies of urban social movements have continually tried to theorise what they actually are (Castells 1983, Lowe 1986, Eyerman & Jamison 1991, and Melucci 1989).

Urban social movements research in the 1950s and 1960s tended to concentrate on the question of why movements appeared. The answers that evolved varied from a focus on the structural problem surrounding movements' inceptions to the psychological interpretations behind the appearance of a new movement. The integration of structural and psychological approaches produced a theoretical approach known as the "collective behaviour" approach (Smelser 1963, Turner and Killan 1972). Great importance was attached to the psychology of individuals and their groups in shaping the form of social protest, particularly in the situation of there being no response to political demands made, which often led to tension and frustration and the need to close the gap between expectations and reality (Turner and Killan 1972). Turner and Killan have argued that it is when members of the public who share a common position concerning the issue at hand supplement their informal person-to-person

discussion with some organisation to promote their convictions more effectively and ensure more sustained activity, that a social movement is in formation.

Neil Smelser (1968), a representative of the structural functionalist school, developed an explanation for the appearance of social movements based on the conception of necessary structural conditions of society which would give rise to an organisation; human activity that would help transform these conditions into organised action, and the governments response of confining and integrating social protest (Smelser 1968, p97 -100).

However, in discussing the more recent literature on Urban Social Movements, Castells' *The Urban Question* is the most obvious starting point as it is one of the most important contributions to what has been termed 'urban sociology', and one of the most influential texts on the study of urban social movements. In his introduction Castells notes that he was influenced by the structuralist approach of Althusser, and it is the structural problem that Castells, like Smelser, places at the centre of his study, with the belief that this in turn shapes the psychology of the participating individuals. The message of this first text was that urban social movements mobilising around issues of collective consumption were the key to changing social relations within capitalist society, and this would be achieved by urban social movements working in conjunction with the working class movement to create a socialist city. Castells argued that urban social movements are more politically advanced and of more consistent quality then most other organisations, (this theme is one that was carried through to his later works), although his belief that urban social movements were organised by the working class changed in his later works.

In his book *City, Class and Power* (1978) there are noticeable changes to the theory which had begun to be advanced in the last chapter of *The Urban Question,* in particular a move away from structuralism. In this new work Castells begins to put forward the view that urban social movements are not dependent on the hegemony of the working class for their existence but are a coalition of members from different classes and may have an autonomous

role in social change. There is a move towards more historically specific arguments as opposed to the more abstract theory put forward in his first text.

While Castells had been leading the structuralist approach to the study of urban social movements in the 1970s a criticism of structuralism had been emerging. This criticism was based on the belief that the focus of the study should be on how the movement became established and structured, in other words the research question moved from why the organisation was created in to how it came into being. The theory that developed became known as the resource mobilisation approach, which criticised the study of structural problems for not being sufficient enough to explain the creation of a movement. The resource mobilisation approach wanted to bring factors of human agency into the arena of study and this was the major difference from the structural functionalist school. This approach was evident in the work of Pickvance (1976, 1977), Saunders (1979) and Dunleavy (1977, 1980). The work of those writers has tended to focus on the processes of mobilisation and less on the social context, whilst Marxist approaches have tended to be in the opposite direction. The main criticism of the resource mobilisation approach lies in the fact that although it comments on the social context of movements, it fails to assess the different levels of the social context and how these interact with the form the movement takes. Important aspects such as ethnicity, values, class and culture are ignored. The resource mobilisation theorists also tended to stress goal-orientated action and place an emphasis on rational or maximising behaviour, thus failing to address important issues such as the movement's and individuals' ideologies and beliefs. These factors were given more importance in the collective behaviour theory.

From the criticisms of the resource mobilisation approach came a new theory which has been termed by Hasson (1992) as the "search for identity". The theory developed as a result of the criticism that the resource mobilisation theory failed to assess the relevance of factors such as the search for a new identity, the desire for political involvement, and the aspiration of self-fulfilment. The main strand of thought that separates this theory from the others is the belief that the members of urban social movements think and act in a different way to the rest

of the society that they live in, they act within a context that they have defined, and in a different manner. The writings of Touraine (1981, 1985) represent this theory. He suggests that social movements struggle against the norms of society represented in the rules that govern society and the economic and social pattens that exist, and that this struggle is at the centre of society as in order to have an impact on society, the movement has to work from the core to the periphery. He relates urban social movements to other movements such as the feminist, student, and ecological movements, stating that although different they are united in their common aim of re-shaping the prevailing culture. Touraine's work on urban social movements has not been developed in depth as some of the other theories have, but as Hasson (1992) states, the main contribution of his approach has been:

> "not in drawing a theoretical linkage between structure and agency (i.e. movement) nor in developing a new theory of pedagogical intervention, but rather in the innovative clarification of the cultural-symbolic meaning of social movements and of the utopian vision they represent." (Hasson 1992, p28)

What is apparent is how Touraine's work went on to influence Castells and change his thinking to the point that finally culminated in his seminal work *The City and the Grass Roots* (1983). What marks the greatest distinction here from his earlier works is that Castells has become more involved with the relationships of consumption, communication and power. Castells now looks at urban social movements in terms of their ability to balance these relationships. Instead of advocating that urban social movements have to be linked to the working-class movements in order to achieve success, in *The City and the Grass Roots* he states that it is imperative for there to be a separation between political parties and urban social movements. Castells begins to distinguish between 'collective consumption trade unionism' groups - groups involved in issues of collective consumption; 'community groups' - groups that have evolved around a specific ethnic, historic, or local issue; and 'citizens movements' -

groups attempting to take on local self government away from central control. Castells argues that all three groups must be united in order to become a 'genuine' urban social movement.

Lowe (1986) explains this change in terms of Castells' new interpretation of the social system, and the importance now placed on personal and group interaction in achieving change in value and meaning systems (Lowe 1986. p 35). Castells distinguishes between urban social movements which operate at the level of the citizen, and political parties which operate within the political level which is detached from the urban citizens. This is why, for Castells, urban social movements are the tenable source of social change, because they involve the citizens of the society. However, because Castells insists on the need for an open political system in order for urban social movements to flourish, this contradicts his stated aim of the purpose of urban social movements (to effect change and social reform). This is because he states that within such an open system, urban social movements are capable of introducing innovation to the social system but are not able to implement it.

> "Without political parties and without an open political system, the new values, demands, and desires generated by social movements not only fade (which they always do anyway) but do not light up in the production of social reform and institutional change.
> (Castells, 1983. p294)

For Lowe (1986) one of the main flaws with Castells' earlier works was that he concentrates on the role of political organisation and the mobilisation process and failed to explore the role of the people who make up the movements. A role which in *The City and the grass Roots* is described by Castells as being central to the analysis of urban social movements, but that Lowe feels has still not been adequately uncovered.

> "Castells has still not integrated a sociological understanding of the importance of the nature and characteristics of social bases in the

mobilisation process; of how a social base becomes, or fails to become, a social force." (Lowe, 1986, p52)

However, Lowe does go on to identify important contributions Castells made in terms of drawing attention to the significance of local communities as focal points of urban movement activity, which Castells suggests are the new social movements which will form the basis of future society. In other words, the importance of examining urban social movements at the local level is crucial to the understanding of their wider activities. This is one of the fundamental contributions made by Castells to the study of social movements. However, the relationship of movements to their local areas is one which has not been explored in any depth by most writers. In this thesis, the importance of locality and identity with the locality through sense of place, are crucial to the formation of the new public health movement.

When returning to the question of defining what an urban social movement is, it is apparent that for Castells the definition has vacillated. However in *The City and the Grass Roots,* he did put forward a definition of what constitutes an urban social movement. He felt that urban social movements should embrace the following objectives:

- They should advance demands based on collective consumption, that is goods and services provided directly or indirectly by the state.
- They should involve a defense of cultural identity associated and organised around a particular locality or territory - the control of space and the activities and relationships that occur in that space are integral to their strategies.
- They should react against centralised forms of state power which might entail demands for political self management, but they should also remain untainted by doctrinine association with other political parties.

This ideal type of an urban social movement was distilled from Castells cross-cultural survey of urban protest movements, however, for Castells, these requirements are only really

found in one movement that he analyses, the Madrid Citizens Movement. Even then there have been criticisms, from Lowe (1986), Pickvance (1985) and Hasson (1990) that Castells has taken a very selective view of history and events surrounding this movement. Castells' influence on research into urban social movements coupled with his narrow definitions contributed to the fact that many protest or social movements went on un-noticed and un-researched because they did not fit into the Castellian model. The promising references Castells makes to Touraine and the importance of human agency, and the fact that the book is dedicated to him are not realised in the end. Castells fails to explain the aspirations of the participants, the organisation and leadership of the movements, and the interactions between the participants. Instead as Hasson (1992) states:

> "Castells presents a linear scheme, according to which the conditions for the development of a genuine urban social movement are the articulation of the economic, cultural, and political conflicts, awareness of them, contacts with professionals, intellectuals and the media, and a link with the political system, while preserving the autonomy of the movement." (Hasson 1992, p34)

What Castells presents us with are a set of criteria or components that he feels are integral to an urban social movement, but no explanation of how they are linked to one another or their significance for the movement. However, this identification of criteria to be met, has been followed by other writers on urban social movements, such as Pickvance (1985), Freeman (1983), Lowe (1986) and Dunleavy (1980).

Pickvance (1985) regards the rise of urban social movements as being related to four distinct structural factors necessary for a movement's inception:

- massive migration from rural to urban areas - creating housing/squatters movements[1]
- State involvement in the delivery of services - creating consumption movements
- the ability of the establishment to absorb the protest (if protests can not be absorbed a state of anarchy might prevail)
- the prevailing economic and social situation (which affects the rise and fall of movements).

Whereas Freeman's pre-requisites are concerned with movements which are far more reactive, she states that the four essential elements involved in movement formation are:

- the growth of a pre-existing communications network
- the network must be co-optable to the ideas of the new movement
- a series of crisis that galvanize into action people involved in a co-optable network
- subsequent organising effect to weld the spontaneous group together into a movement.

Dunleavy (1980) makes a clear distinction about what may be considered an urban social movement, by describing movements in terms of the qualities that they have which differ from conventional pressure groups and voluntary associations, despite them having similar grassroots orientations. These include a "bottom-up pattern of local organisation largely unintegrated into national or regional level institutions; their relative un-involvement in or distance from formal political activity; an undeveloped or restricted organisation hierarchy, giving direct participation in organisational direction by the movement's social base; a relatively high level of grass-roots activism; the use of mobilisation techniques; and the representation of the interests of relatively powerless groups" (Dunleavy 1980, p157.) Lowe (1986) shares this broader definition of urban social movements

"Organisations standing outside the formal party system which bring

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[1] Pickvance was mostly concerned with urban social movements operating around issues of housing.

> people together to defend or challenge the provision of urban public services and to protect the local environment. The implication of these organisations as 'social movements' is that their objectives are undertaken collectively by the mobilisation of a distinct social base and that the momentum of their activity is towards changes in policy direction." (Lowe, 1986. p3)

This definition given by Lowe helps us to understand what Dunleavy means when he says that urban social movements are unlike other voluntary associations, the difference being that urban social movements are mobilising around a particular social base. When analysing cross cultural theories of urban social movements, Lowe points out that we should avoid the structure laid down by Castells and Pickvance, and instead focus on the "mobilisation process: the arena of action and non-action" (Lowe 1986 p51), and that we should concentrate on themes that link urban social movements and not the structures that they are part of. Lowe suggests that we should analyse the themes of the movements under two broad headings: those relating to political process and those relating to social process. Under the heading of political process, he suggests that the themes we might analyse are:

- the structure and political history of the local administrative system and its interaction with the central framework
- the party political system in the society and its effectiveness in mediating social conflict
- the osmosis of activists between urban movements and the party system, and the existence of alternative sources of activism
- the identification of those economic and social forces that underpin the national and local state
- the need to be sensitive to intra-national variations in urban movement experience.

Under the heading of social process the Lowe's themes mainly concern the social base from which action may be spawned:

- the stage of urbanisation - including the role of consumption
- social and demographic adaptation to national economic development.
- scrutiny of the mediating associational and social network factors that might screen out protest and the identification of solidaristic communities which might generate a movement.

Although useful in a cross-cultural examination of urban social movements these criteria do not help in the analysis of urban social movements within a single state, or concerning the same issues, as the criteria are addressing the comparisons or differentiation between movements based in different areas. If this approach was to be taken for the public health groups in Tower Hamlets, the answers to each of these points would be similar for each of the groups, and this would not bring us any closer to the reasons why each of the groups operates in different ways with different objectives. The differences are due to the social networks, and internal organisation of the groups.

Again both Dunleavy's and Lowe's definitions of urban social movements, like Castells', fail to address the different interactions and consequences of the factors they describe. As Hasson states:

> "the forefront of research in the field of urban social movements is still stuck in a search for macro-societal explanations and does not advance our understanding of the role of human actors who in the course of searching for identity construct the meaning of movements." (Hasson 1992, p 39.)

In analysing the three study groups in Tower Hamlets as expressions of urban social movements, primary focus will be placed on the role of human agency, as this is one of the key factors which determines the activities and success of each of the groups. As will be discussed in chapter four, the focus throughout this thesis is on the individual, and the locality, not the macro scale. There are obvious advantages of cross cultural comparison of urban social movements, however, this is not within the scope of this study. The purpose of this investigation is not to achieve a definitive explanation and definition of urban social movements, but is concerned with the interpretation of the work of three groups around public health issues, in a specific locality within the context of urban social movements. Castells in his later works (*The City and the Grassroots)* is one of the few writers to place emphasis on the focus of research being at the local level, and the importance of the local space to the formation and characteristics of the movement. The critical difference between previous writers on urban social movements and this study can be explained in terms of the approach. Previous writers have been concerned with definition; whereas this research is concerned with the interpretation of the activities and action of three groups who are part of the new public health. The interpretation will act as a case study from which to draw some wider conclusions about the nature of the new public health movement. In analysing the public health groups in chapters five and six, an emphasis will be placed on the interaction of participants, their aspirations, their achievements, the group dynamics and as Touraine would advocate - their utopian vision and interpretation of the local culture in which their group operates. Chapter seven will then demonstrate the need to examine place in the context of an urban social movement, in terms of how place actually plays a significant role, in mobilising participants and shaping and focussing the work undertaken.

Some of the factors described by writers such as Castells, Lowe, Pickvance and Dunleavy will be used in the analysis, in terms of trying to see how the groups match criteria laid down by these writers. In addition key elements of the different definitions of what constitutes an urban social movement will be discussed in relation to the three study groups. As discussed in the introduction to this section, there are three common directions that all studies of urban

social movements have taken, and these will be examined, they are: 1.why the movement came into being; 2. how does the movement organise itself, and 3.what is the significance of the achievements of the movement. These three important themes are at the centre of all the different approaches to the study of urban social movements. Within the collective behaviour approach importance was placed on the first question, the structuralist approach focussed on the achievements of urban social movements in terms of their effect on society (the third question), and writers such as Lowe and Hasson are concerned with the individuals within the organisation and how the organisation is structured and arranged (the second question). After analysing these three questions, it will be possible to see whether and how all three study groups do fit within the interpretation of what constitutes an urban social movement.

At this point it is necessary to lay down the interpretation (not definition) of what an urban social movement is taken to be in the context of this study. An urban social movement is a voluntary association of members who have come together to work towards a common aim. The aim of the group can be explicit or implicit i.e. the group may have definite targets to reach or an overall guiding objective. However, common to all groups will be the aim to improve an aspect of society, or perhaps more accurately, the way society approaches a particular problem or issue. The group will have a strong attachment to a particular place, with good knowledge of that place, which will be the key to providing the issues that unite the group, and provide the focus for attention. The place does not have to be an entire city or town but may be an urban locality, with definite administrative or social boundaries, on which the group agree. The members of the group may be made up of people from different classes, occupations, ethnic groups and gender, but all will share the common aim of the group. The differences between them will lead to greater knowledge, experience, approaches and attitudes that can be shared. The groups will tend to operate in an unhierarchical manner, and be as democratic as possible. Action, activities and progress will be led by the will, enthusiasm and commitment of the members. The key elements to stress are: the common aim of the members; the voluntary nature of participation within the group; the shared identity of place; the importance of democracy; and the pluralism of group members.

The theories of urban social movements discussed in this chapter do not account for a movement such as the new public health which is a global movement, organised at the local level. Because it is organised at the local level, individual groups working at this level, operate in different ways, with different approaches and motivations, yet all feed into the movement at an international level through initiatives such as Health For All and the Healthy Cities Project. The literature does not account for the differences in the movements organisation at the community level, yet this it is these differences which sustain the new public health movement and allow it to grow because it can be tailored to the needs of specific populations. As Hasson points out above, it is the individual agents within movements at the local level who construct the meaning of the movement, which is why the overall goal of the new public health is the improvement of health and reduction of inequalities in health. This goal is manifested in a variety of approaches from a variety of organisations, each characterised by the individuals participating. Another important element in the new public health movement is the fact that the local environment plays a central role in shaping the form of the movement at the local level, in that it is the physical, social and economic environment that public health is concerned with. In order to improve the public's health, activities need to be tailored towards the needs of the specific environment in which the movement is organised. The literature on urban social movements has failed to take into account the importance of the specific environment (or place) in relation to a movements formation or direction, and its overall effect on shaping the form the movement takes. One of the central themes of this thesis is to demonstrate how place, and in particular sense of place, is one of the most important factors to explore when studying the new public health movement.

## 2. Sense of Place - Theories and Concepts.

Place as a concept of geographic inquiry has its roots deep in geographic thought, as Entriken points out "Geography has been described as the science that derives from the naive experience of the similarities and differences among places" (Entriken 1991, p10). However, within the timescale of geographic enquiry the concept of 'sense of place' has only begun to be explored much more recently since the mid 1970s. According to Yi-Fu Tuan "space and place together define the nature of geography" (Tuan 1974, p213). The view of examining place as an holistic concept can be traced back to the 19th century German geographers Carl Ritter and Alexander von Humboldt who examined place through regions in the context of being miniature examples of the world. This view of place gradually diminished in importance, and it has mainly been the concept of space that has dominated geographic discourse, particularly through the positivist traditions of spatial analysis linking objects and events to their locations. However, a revived interest in humanistic geography in the late 1960s and early 1970s brought with it a search for meaning and value in peoples experiences of everyday life. The emphasis has now switched from studying space, as an abstract entity, to place, and its meaning for people. As Eyles states "the study of place from a humanistic perspective has emphasized introspection, contemplation, and speculation" (Eyles 1985, p32.). More recently there has been a call to set place at the centre of all geographical studies, in an attempt to unite what some geographers see as an increasingly fragmented discipline (Stoddart 1987, Harvey 1990, Johnston 1991a).

In reviewing the historical development of 'place' studies it is perhaps most appropriate to start with the French regional geographers and their concept of *milieu,* a concept that includes both natural elements in addition to human constructions (Entriken 1991). As pointed out by Entriken, the main focus of this group of geographers was to "describe and understand the natural context associated with particular ways of life" (Entriken 1991, p6). It was the French geographer Videl de La Blache who laid the foundations for place studies by trying to examine all the elements in the relationship between man [sic] and his environment in a variety of

regional studies, which took place at different geographical scales and locations throughout France. As Berdoulay points out "Videl's book La France de l'Est (1917) is an excellent illustration of the importance he attributed to the "vie de relation" [the relationships within the area] in shaping that region" (Berdoulay 1989, p126). The Videlian school has often been criticised for being set within the contexts of radical possibilism and regional descriptions that characterised much of early geographical discourse (Gregory 1978, Buttimer 1971), and that it has little to offer place studies from this perspective. However, Berdoulay argues that "Videlian possibilism is best characterised as a broad theoretical framework devised for avoiding both radical possibilism and environmental determinism", that the point of Videl's work was to examine the interaction of the elements, and to explain the relationship between people and their environment, by examining their feelings. It is in this context that the Videlian research tradition can be thought of as the earliest example of 'sense of place' studies. Following on from Videl, other French geographers explored place at various scales and at various levels of detail (Gallois 1908, Demangeon 1905).

The Videlian school of geography attracted the attentions of historians who valued the contribution that regional studies could make to their discipline (Mann 1971). However, at the same time as the historians saw the value of examining the contribution of place, and societies relationship to it, geographers began to lose interest. Place as a concept for geographical inquiry was 'overtaken' by the emphasis on research space, this was related to the quantitative revolution that occurred in the social sciences in the mid twentieth century, and the tradition of positivism (Scargill 1985); research space is abstract space, a space in which models can be developed before being applied to a place. Quantitative geography emphasized location and space, its techniques were based firmly on statistics and model-building, in stark contrast to the descriptive regional studies (Johnston 1991b), and the research was highly theorised and abstracted from reality. As Tuan points out it is common to assume that "geometrical space is the objective reality and that personal or cultural spaces are distortions" (Tuan 1974,p215). Examples of world renowned research undertaken include Cristaller's central place theory (Christaller, 1966); Hägerstrands concept of activity space and innovation diffusion modelling

(Hägerstrand 1969 and 1968) and Haggett's locational analysis (Haggett et al 1977). It was this form of spatial analysis that remained at the forefront of geography throughout most of the 1950s,1960s and early 1970s.

During the 1970s and 1980s there was a resurgence of the focus on place, and in particular on sense of place, which coincided with the growing emphasis on behavioural and humanistic geography (Johnston 1991b).[2] Research became focussed on the differences between places as a result of the way we view them rather than viewing the differences as an essential element of how the world is, in the way that spatial analysis had. One of the main criticisms of cross cultural comparative studies of urban social movements such as Castells (1983), are that the diversity of place cannot be adequately represented within a single model. As Pickvance tried to point out, there should be a set of linked sub-models each corresponding to a different concept of urban, of which he laid down three models (Pickvance 1985). In the first half of this chapter we began to see how the literature on place was undervalued in the study of urban social movements. This author would argue that even Pickvance did not go far enough, and does not put enough emphasis on the uniqueness of place, and on the (unique) individual and group perceptions of place that are the fundamental elements behind the structure of the urban social movement that is being researched. The work in this thesis is centred around what effects these differences in perception have on the actions and events occurring around public health activities in Tower Hamlets within several groups, rather than what effects the actual construction of the place has on their activities.

Places are in a constant state of flux, they are ever changing, but despite this fact, places continue to make sense to individuals. This is because places have specific meaning for different individuals and the individual interpretation and meaning of a place is also capable of changing. The key factor to recognise in understanding the context of place is the part played by individual meaning and interpretation:

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[2] See Appendix C for an account of changes in literature on place during this time.

"meaning is the key to the importance of places; the subjective experiences that people have within places gives them significance"
(Gesler 1991, p 3 )

A useful definition of place can be derived from comparing concepts of place with those of space. For example, space is an abstract and universal concept, whereas place is grounded and specific. Place has meaning and experience for individuals, whereas space is analysed in more quantifiable terms, in order that everyone can understand it. The term sense of place has two related meanings within geographic discourse. It can be:

"A characteristic of a place itself that is memorable or distinctive, having a high 'imageability', thus particular cities, symbolic or sacred locations.....may be said to have a strong sense of place."
(Eyles in Johnston et al 1986, p425)

Secondly, sense of place can be defined in terms of:

"The consciousness that people themselves have of places that possess a particular significance for them, either personal or shared."
(Eyles in Johnston et al 1986, p425)

It is therefore apparent that sense of place derives not only from a place's characteristics, but also from the ways various individuals and groups perceive places. If we take the example of community, we see that the relationship between community and place is a powerful one in which each reinforces the identity of the other. Often places are defined in terms of the communities who live there. This is often due to the physiological characteristics associated with people from a particular area, for example the red hair, and 'temper' of the Celtic people associated with Scotland and Northern Ireland. However on a more abstract level there are associations or relationships given to people and their place such as the common perception of people living in the country as being more healthy, physically more developed, and perhaps

mentally less developed. In contrast to how outsiders perceive relationships between communities and place there are some communities or individuals that deliberately seek a closer relationship or tie by the clothes they wear or changes in culture that they take on. An example of this is second generation Bengali immigrants to Tower Hamlets where the young have adopted western dress, speak with 'cockney' accents, and have adopted other behavioural patterns of the indigenous young people such as eating fast food, playing football, and spending time together in large gangs. This process of assimilation that many migrant groups go through is inextricably linked to the place that they have migrated to and the prevailing local culture. Other communities identify their relationship with place in less personal ways, for example by joining a local tenants or residents groups. Through various groups people identify sufficiently with the local area to attempt to protect it against outside forces for change / development (Relph 1976).

Perception is the key component in studies of place, mainly because experiences of both places and people are so diverse. Place becomes meaningful and tangible through experience. Thus the study of both place and the sense of place requires a different approach from the quantitative approach usually employed in an spatial analysis. According to Relph:

> "Place and sense of place do not lend themselves to scientific analysis for they are inextricably bound up with the hopes, frustrations, and confusions of life and possibly because of this social sciences have tended to avoid these topics." (Relph, 1976. Preface)

In other words place is essentially experiential, and for these reasons the examination of place and its relationship to the groups carrying out public health work in Tower Hamlets, is in terms of the experience of Tower Hamlets as a place to work and live. It is centred on the observations and knowledge of the individuals who make up the groups - what can be described as the lifeworld of those people. This concept of lifeworld has been described by Buttimer as "the pre-reflective, taken-for-granted dimensions of experience, the unquestioned

meanings, and routinized determinants of behaviour" (Buttimer 1976, p281.) In order to study the concept of the lifeworld a phenomenological approach has been advocated in order to understand the actions as those who are involved understand them, rather than in the abstract; detached from the context of their everyday behaviour.

The concept of the lifeworld has received criticism for neglecting the external constraints placed on individuals and the consequences of their action (Gregory 1978) but these criticisms have been directed more towards the methodology of phenomenology than the concept of lifeworld. Gregory advocates that a geography of the lifeworld must analyse and understand the relationship between "social typifications of meaning and space-time rhythms of action and uncover the structures of intentionality which lie beneath them" (Gregory 1978 p139). The concept of lifeworld still has much to offer place studies in geography, and has suffered due to the lack of practical application of this concept.

In the late 1970s and early 1980s 'sense of place' studies were criticised, and much of the literature drawn on in this thesis from the the 1970s (Relph 1976, Tuan 1977) was disparaged. In 1981 in an article in Transactions of the Institute of British Geographers, Derek Gregory criticised the literature for failing to make the necessary links between action and structure, and for being too narrow in their interpretations. There was also criticism by Gregory at an earlier stage that the concept of sense of place had not been applied in the field, to research practice, and that there was a need to work through the questions raised about the nature of the relationship between communities and their environment in "concrete studies of real places and landscapes" (Gregory 1976 p 298). There were also criticisms that not enough emphasis was placed on the role of time (Cosgrove 1978). These are valid criticisms however, even though the literature is almost twenty years old, some of the theoretical ideas about sense of place that writers such as Relph and Tuan presented have relevance for place studies carried out in the present. This author advocates going even further back in history to draw on Kevin Lynch's seminal work *The Image of the City* (1960). One of the key aspects of Lynch's work on the practical value of studying image is that he advocates that there is a

"public image of any given city which is the overlap of many individual images" (Lynch 1960 p46). The importance of this view lies in the link that can be made to collective action and collective behaviour and thus urban social movements. Much of the work discussed in the early part of this chapter noted how there needed to be a common bond with the urban area, and the issues under consideration, in order to give rise to a social movement. What the authors (Castells, Pickvance, and Dunleavy) failed to point out was how this could be achieved through the common perception of the city. As Relph points out

> "through interest groups, communities can develop and an image can be projected in which the identities of places of significance to that group are a reflection of group interests and biases" (Relph 1976, p57).

In this thesis human agency is an integral part of the understanding of both urban social movements, and sense of place, and thus the criticisms directed towards the work of authors such as Relph and Tuan may be avoided. In addition the empirical work carried out is grounded firmly in practice, within a particular community, and thus avoids the further criticism by Gregory that sense of place studies were not grounded in practice. Since Gregory's criticisms of studies on place there has been a gradual revival in their interest and position within geographical discourse.

In the mid 1980s 'place' studies were revived, and the focus of attention widened to take account of the earlier criticisms. There was a call for an interest in place studies that could take account of how structural processes affect particular communities and localities (Harvey 1984, Jackson 1986). Humanistic geographers continued to investigate sense of place, and in 1985 John Eyles published his book *Senses of Place*. Other geographers such as Massey (Massey and Allen 1984) argued that there was an integral and reciprocal relationship between society and space. The point of these discussions in the mid 1980s was not to return to the old style regional geography and areal differentiation, but to encourage geographers and other social scientists to incorporate place as an essential element of any inquiry. As we have seen in the

analysis of urban social movements place is often undervalued and underplayed. Yet, as this thesis seeks to demonstrate, place is an essential element in explanation.

Agnew (1989) in his chapter *"The devaluation of place in Social Science"* commented that one of the reasons place has been undervalued is because "within much social science two other concepts, those of community and class, have dominated to the extent that thinking and talking in terms of place has been largely impossible". Agnew goes on to say that a revival of place should not be to the exclusion of other concepts such as community or class, and that in fact there is an important relationship between these concepts, but that place should be just as important. One of the explanations put forward for the devaluation of place is that the concepts of community and place have been confused. A further reason for the devaluation of place is that, as we have seen, place studies have tended to be in one of three frame works. As Agnew and Duncan (1989) point out:

> "Economists and economic geographers have emphasized location or space sui generis, .....humanistic geographers have concerned themselves with the locale, the settings for everyday routine social interaction provided in a place. Thirdly, anthropologists and cultural geographers have shown interest in the sense of place..... Rarely have the three aspects been seen as complementary dimensions of place." (Agnew and Duncan, 1989, p2).

The recent revival of interest in place is directed towards integrating different aspects of place studies in order to achieve a more comprehensive study of geography. The concept of place in this study is used to elucidate how action around public health relies heavily on environmental perception and sense of place. It focuses on how the scale of place affects the interaction between group members, and how place and identity with place, is an essential mobilising and structural organisation factor for urban social movements; which is an attempt to mediate between the three frameworks set out by Agnew and Duncan. The importance of studying place in human geography has never been so salient, as Stoddart points out:

"Human geography as an exclusively social science loses
its identity - it competes with sociology, economics, anthropology
- but on their ground, not on ours." (Stoddart 1987, p330)

What is being pointed out is that as geographers develop ideas and move into the wider social science network we have to hold onto an essential premise of geographical inquiry, namely place. That is our key difference to exploration from the other social sciences, and hopefully our key difference which will enable us to reach a more comprehensive answer to the research questions. Grounding our research in an analysis of place is the only way that we will be able to compete with the other disciplines within the social sciences, and the only way that we can unite as a discipline. As Johnston points out in the introduction to his book *A Question of Place* , when analysing the various pleas put forward by a number of geographers for a re-integrated discipline:

"A major task essayed here is promotion of the concept of place
as a central, integrating core for geographic work"
(Johnston 1991a p 3)

The purpose of this chapter has been to explore the theory behind the concepts of urban social movements and sense of place and to provide an historical chronology of their development. Both these concepts are central to the study of the new public health movement, particularly in the context of this thesis, which is examining the new public health at the local level. The next chapter provides an account of the methodology used in this thesis in order to analyse the new public health in terms of being an urban social movement, and the importance of the relationship it has to place.

## CHAPTER 4

# METHODOLOGY

This purpose of this chapter is to set out the methodology and methods used in the research on which this thesis is based. Nearly all work on public health issues within a geographical context has been carried out from a much more 'medical' perspective, looking at health needs, health resources, epidemiology, and accessibility and utilisation of health resources. (Eyles and Woods 1983, Jones and Moon 1987). This thesis examines the new public health in the wider context of how public health relates to the social, physical and economic environments; how it is more than just a division of health care and provision, but is related to the structure of society, and the way that society deals with health issues. This is done in two ways: firstly by examining the new public health as an urban social movement, whose aim is to reform the approach taken to public health; and secondly by analysing the importance that public health has in our everyday lives by exploring the relationship it has to the physical, social and economic environment in terms of sense of place. In order to examine these issues, the research has been centred on one locality, Tower Hamlets, which acts as a case study from which some wider conclusions can be drawn.

The chapter begins with an analysis of the methodologies that have been traditionally used within the sub-discipline of medical geography, which have been quite limited in their scope compared to the methodologies used within the rest of geography and the social sciences. It then moves on to outline the methodological approach of ethnography, the methodology used in the construction of this thesis but one that is not widely used in traditional medical geography studies, and concludes with a section on the methods or tools used to collect the data used.

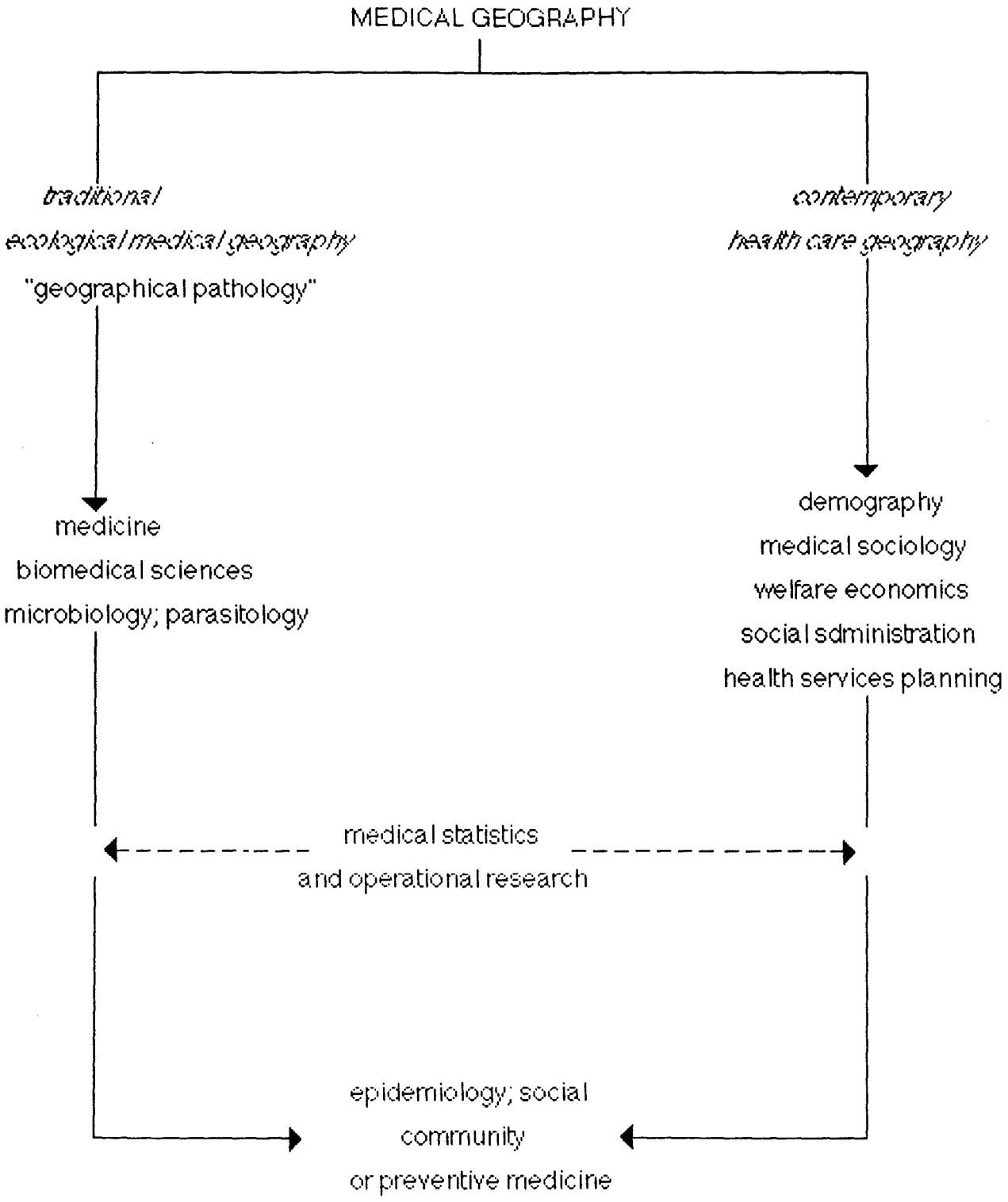
## 1. Medical Geography

The term medical geography is used as a general term to include all the various aspects of the discipline. Some authors have made a distinction between the terms medical geography and the geography of health and health care. For the purpose of this document the term medical geography will be used to cover all aspects of research involved with illness, health, health care, and health services, carried out within a geographic framework i.e. studies which situate themselves within the discipline of geography, or that include an analysis of space, place or landscape as an integral element of the study. This may in fact, be a somewhat broader perspective than that which is normally implied by the term medical geography.

The methodologies used within medical geography are drawn from a number of different disciplines outside of the area of geography including medicine, sociology, epidemiology, economics, anthropology, and politics. A useful summation of the linkages to other disciplines in medical geography has been drawn up by Phillips (1981) [See Figure 1]. A number of methodological approaches or perspectives can thus be found, and classifications have been made by many writers (See Jones and Moon 1987, Eyles and Woods 1983, Pyle 1979, and Phillips 1981). The approaches have been classified in different ways by different authors (the classifications tend to be a mixture of method, methodology and subject area), but in general, studies have been grouped into six main areas : Biomedical, Medical Cartographic, Economic/Political Economy, Behavioural, Welfare, and Social Area Studies or Medical ecological.

The sub areas in medical geography are mainly distinguishable from one another by the different methodologies that they use, however methodologies and approaches do overlap. In medical geography the approaches taken have been within two clear research traditions the first concerned with the cause and spread of disease, and the second concerned with the

**Figure 1** **Some Interdisciplinary Linkages of Medical Geography**




Source: Phillips (1981) p 6

provision and consumption of health services. To some extent these divisions still persist in medical geography, and one of the questions that is raised is whether this division is due to the research frameworks or to the methodologies that they use.

D M Smith in the dictionary of human geography says " the distinction between the study of health status and the provision of health care remains clear enough for them to be considered separately." (Smith in Johnston et al 1986 p293). However, it is arguable that it is no longer desirable to separate these two traditions as it was before. This is basically due to changes in methodological frameworks used within medical geography research. Previously most research carried out within the field of medical geography was concerned with quantitative methods (Curson 1984, Gardner 1976, Harvey 1969, Moriarty 1973) however, recently there have been studies which have been concerned with issues relating to illness and disease rather then health care, which have relied predominantly on qualitative methods, most notable are Cornwell (1984) Donovan (1986) and Eyles and Donovan (1986), who used ethnographical approaches. Qualitative work of this kind has been a major breakthrough in terms of advancing medical geography as a discipline. Both Donovan and Cornwell are answering the pleas from Jones and Moon (1987) and Eyles and Woods (1983) for a more comprehensive look at health within the wider totality of society.

In the last 15 years medical geography has undoubtedly undergone a shift from a geography of disease to a geography of health care. Both Jones and Moon (1987) and Eyles and Woods (1983) argue that the focus of research should now shift to the totality of health and society. This shift is also complementary to the change in direction taken in public health, in that the new public health has its focus also on the totality of health and society encompassing the political, economic, social and physical environments. To quote Jones and Moon "the shift requires us to examine economic, social, and political processes which in turn necessitates the removal of academic boundaries to provide a full understanding of the social world." (Jones and Moon 1987, p 359). Jones and Moon are advocating the use of methodologies borrowed from other disciplines in order to provide a more comprehensive

framework for the analysis of health and its relationship to the totality of society. This is important in terms of the questions that have arisen in the context of this work, and its wider perspective on the new public health, in terms of being an international urban social movement, and also in terms of the strong relationship between public health and the totality of the physical, economic and social environment. A shift towards looking at health in the context of wider society implies a particular starting point, and thus a particular methodology which in the case of this research, is the approach that comes from the way in which the researcher observes the wider society; in the methodology of ethnography.

One of the reasons hypothesized by this author, is that research on health carried out within a geographic perspective has had a much narrower focus than the 'totality of society' perspective called for by Eyles and Woods, and Jones and Moon is because research carried out within the field of medical geography is often funded by the Health Service directly or indirectly, or is done in collaboration with the health service. One of the great problems with attempting to use a more qualitative framework for investigation is that very often the managers and doctors within the health service are reluctant to use such methods. There are a number of reasons for such reticence. Managers often commission research in the hope that it will elucidate information which will help them provide a better or more appropriate service, or that they will be able to ask for more resources for a particular area as a result of research undertaken (research which could be carried out within either a quantitative or qualitative framework). However, the research that they are more interested in is quantitative, as they feel numbers help to justify decisions more then qualitative data, there is an implicit validation of quantitative data, that does not exist for anything more qualitative. Other reasons for the bias towards quantitative work, comes from the fact that the medical profession leans very heavily towards the natural sciences and 'scientific methods' of investigation, and therefore qualitative methods are not considered appropriate.

Human Geography as a subject has developed various methodological frameworks over time, which are related to the various sub-disciplines within the subject. More and more

methodological frameworks are being imported from disciplines outside of geography, as researchers experiment with different ways of gathering and interpreting data (Johnston 1991b). However, it appears that Medical Geography as a sub-discipline seems to be slower in picking up new methods and methodologies, and this may be attributed to the sources of funding for the research, and thus the stipulations for the type and methods of the research given by the funders. The argument is not that medical geography has not taken on board any of the advances made in other areas of geography; techniques in medical geography have shifted from empiricism and instrumentalism to realism. However, medical geography has been more conservative in its use of alternative frameworks for understanding, and it is not considered to be at the 'cutting edge' of geography in respect to current trends and ideas.

The limitations placed on medical geography by the medical profession, the health service and by the orthodoxy of medical geographers themselves led to the search for a more interpretive, and less quantitative methodology for this thesis. The methodology that is employed is that of ethnography, also used by Donovan, Cornwell, and Eyles and Donovan. Ethnography has much more support from other social sciences, particularly sociology and anthropology than it has from geography. The outline in this section of the methodological approaches and the types of studies that have been traditionally taken within medical geography, serve to highlight the differences that they have with an ethnographic approach. Ethnography and other qualitative and interpretative methodologies, will help the sub-discipline of medical geography move into new areas of research, as well as re-examining older areas within a fresh perspective.

## 2. Ethnography

The research presented in this thesis is set within the sub-disciplines termed as medical geography (see Eyles and Woods 1983) and social geography (see Jackson and Smith 1984), there are also elements of welfare geography (see Smith 1977) within the work. Social

geography and welfare geography have moved on from the descriptive research of areal differentiation that preoccupied the seventies to more process orientated work (Smith in Johnston et al 1986). Explanation now tends to be sought at two different scales, the first looks at the economic-social-political system as an integral whole e.g. analysis of capitalism, or socialism; the second level of explanation is concerned with the details of how an economic-social-political system might operate at the local level (Jackson and Smith 1984). In terms of the research in this thesis, emphasis is concentrated on the second level, although the research is influenced by recognition of the wider economic-social-political capitalist system operating in this country. The National Health service, Education, and Welfare services are suffering under the policies of the present government (Radical Statistics Health Group, 1987), and this is directly influencing the rise in protest and action groups from the community, as well as groups who are trying to implement or reinstate services in the wake of government cuts.

Social geography is as much a product of events in society as of the nature of geographical enquiry. As Smith (1986) says "the re-direction of human geography towards welfare issues corresponded to a major shift in societal concern, from narrow economic criteria of development or progress to broader aspects of the quality of life, this in turn led to some geographers stressing social responsibility, and who also sought a positive relevant role in combating contemporary social problems" (Smith in Johnston et al 1986). The argument is not that all research should be policy relevant, however my own beliefs are that the researcher should be able to justify her own work in some way (See Stanley Ch 1, 1990). I feel there is a need for research to have some relevance to change, or development in some form. I think that this is particularly pertinent to social or welfare geography, where I feel there are what might be termed as ethical considerations about why one carries out research and for whom one carries out research. One of the motivating factors for my choice of this area of research was in the hope that it would be possible to identify areas of good and bad practice, which might be fed back and eventually have some effect on the way that public health is viewed and public health activities are carried out. The strong involvement I have developed with the

groups that I am researching, and the way I view society, have meant that I have chosen an ethnographic approach to studying my topic.

Ethnography has its main background in cultural anthropology, however it is now accepted as an integral part of interpretive sociology and to a lesser extent interpretive geography. Ethnography draws upon symbolic interactionism, phenomenology, hermeneutics and ethnomethodology. Its central focus is on understanding the attitudes and contexts of the people under study, including the context of their everyday lives (Hammersley and Atkinson 1983).

Ethnography requires an intensive personal involvement, and great importance is placed on the reflexivity of the researcher. It is important to remember that ethnography is neither subjective nor objective but is interpretive. Giddens (1976) talks about ethnography at its core being a process of 'mediating frames of meaning', that is, providing an interpretation of the researched for an audience to understand, as well as providing that audience with the resources to be able to make sense of the experience/subject that is being researched. One of the key aspects of ethnography is that the researcher's loyalties should be with the people/place/objects or phenomena under study and not to the methodology, or particular principles of that methodology (Znanieki, quoted in Burgess, 1982). Another key aspect of ethnography is that if two ethnographic studies were carried out on the same topic they would differ considerably because the researcher is so integral to the approach. This was one of the main reasons for deciding on an ethnographic approach as I have always had difficulty in reconciling pieces of research which give no background information about the researcher, their reasons for deciding on the subject, and their opinions. This is information that I feel is crucial for the reader or audience in order that they can fully understand the wider context of the research. As Moustakas (1990) states in his phenomenological approach, research begins with "a devotion and commitment to pursue a question that is strongly connected to one's own identity and selfhood."

Thus information about myself will be integrated into the text where appropriate, but some basic biographical details important to my identity can be given here. I am a British Asian, I am a young woman, I am a feminist, and I am from a middle class, mixed heritage, background. I have been a resident of Tower Hamlets for seven years. These factors all influence my research at a number of different levels, for example my colour and sex made it easy for me to discuss issues of sexism and racism during the course of the research and enabled me to empathise with respondents of similar sex and race, however these same factors proved to be barriers in understanding when I talked about the same issues with white men. Another important factor about myself, relevant to this research, is that I place a great deal of value on supportive and counselling relationships, and this became an integral part of my research approach[1]. My interest in health developed whilst at school, and although I did not pursue a career in the health service (apart from a short spell as a nurse) I maintained my interest in health through courses taken at university which related to geography and health. My interest in public health in particular developed after I had graduated and was working as a research assistant on a number of health related projects in Tower Hamlets, including organising a series of seminars on Health For All 2000. After the seminar series had finished I sought funding from the Department of Public Health in order to carry out the research for this thesis.

Agar (1986) in 'Speaking of Ethnography' summarises ethnography in the following way:

> "Ethnographers set out to show how social action in one world makes sense from the point of view of another. Such work requires an intensive personal involvement, and abandonment of traditional scientific control, an improvisational style to meet

[1] The types of counselling I am interested in are person centred counselling and re-evaluation co-counselling. It is important to distinguish these from the 'medical model' of counselling as a cure for mental illness. These types of counselling are 'everyday' counselling and although they can be used with people who are suffering from mental illness; they are predominantly practiced by people who are not suffering from any kind of mental illness, but are used to enhance and develop peoples' lives.

situations not of the researchers making, and an ability to learn from a long series of mistakes." (Agar 1986 p 83)

One of the main differences between ethnography and other methods is that the power relations between the researcher and the researched are more equal, as the researcher is attempting to interpret the events rather than to test or to observe independently as in a laboratory experiment. Agar (1980) and Donovan (1986) suggest that it is the informant who has all the power, however I feel that although ethnography is about interpretation of events; the researcher has an idea about what aspects of the informants she is going to study beforehand, and the researcher has the power of interpreting the events for the research, and this ultimately gives her more power in terms of the relationship. Since the researcher has some knowledge that is not shared by the researched, that knowledge equates to some power. In addition, some of the techniques used in ethnography, namely participant observation, do not lead to equal power relations when one party (i.e. the researcher) is 'acting' a role.

As a woman, a feminist, and a researcher, I have sought an approach to interviewing and research which does not uphold the values inherent in traditional structured interviews. Oakley, (in Roberts 1981), a feminist researcher denotes the values upheld in structured interviews as 'detachment', 'objectivity', and 'hierarchy'. The importance of detachment in interviews has been valued in the past because it apparently minimises bias on behalf of the researcher. However, there is now much research within psychology and psychotherapy, as well as from within the social sciences, to suggest that the researcher is not able to eradicate bias from the situation in this way (see Pile 1991). I argue that detachment in the interview situation leads to a greater loss of information within the research process, as a less intimate situation can lead to less information being shared, and can also mediate against interpretive understanding. As Oakley says, interviewing is most effective "when the interviewer is prepared to invest her own personal identity in the relationship....[as] personal involvement is

more than dangerous bias, it is the condition under which people come to know each other and to admit others into their lives." (In Roberts 1981 p 33).[2]

The second criteria mentioned by Oakley of 'objectivity' can be seen as a value inherent in structured interviewing, particularly in relation to the way the research participant is viewed by the researcher. Mearns and McLeod (1984) state that "the individual or group is experienced by the researcher as an object of study rather than as a person." The extent of this is evident when the individual's material from an interview is turned merely into a number for statistical analysis. Oakley states that in this case the objectivity "takes value over people's more individualised concerns." My interest lies as much in the differences between peoples accounts, experiences, and attitudes, as it does in their similarities, thus to reduce information to a structured form and to 'smooth the edges', detracts from the data instead of enriching it with the details of personal and subjective accounts.

The third criteria of hierarchical values that are upheld in structured interviews relates to the relationship between the researcher and research participant. Mearns states that "in this social context, where one person is defining the relevance of another, it is not surprising that an authority relationship develops" (Mearns and McLeod 1984). I view hierarchical relationships as undesirable, as they replicate the oppressive power relations that exist between men and women, between classes, and between cultures and races, and therefore I would not want to incorporate them into my research, whether in interviews or meetings. In fact as Oakley states " it becomes clear that in most cases, the goal of finding out about people through interviewing is best achieved when the relationship of interviewer and interviewee is non-hierarchical" (In Roberts 1981 p37), (See also Cornwell's work (1984)).

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[2] See Cornwell (1984) and her description of public and private accounts when interviewing, and how close relationships are able to elicit more 'private' information .

A person centred approach is one that emphasises the validity of subjective experiences and stresses the importance of an equal as possible relationship between researcher and research participant. It is phenomenological, humanistic, qualitative, and integrates well within an ethnographical approach. I first came across this approach in the course of person-centred psychotherapy (Rogers 1989c), however Carl Rogers (the founder of the approach) also applied it to research into different fields of life such as education and the caring professions. The person centred approach is concerned with personal emotional growth, and the actualising tendency, which is the term given to the act of striving for personal growth. In order for personal growth to take place it is necessary that three conditions are present: unconditional positive regard; congruence - being yourself as a person (genuineness); and empathy - the ability to take a life perspective of others, i.e. putting yourself in anothers place and sharing their feelings. Therefore the degree to which the people I meet in the course of the research process feel that their relationship with me offers a growth promoting climate is dependent on the degree to which I view them as equals, and the degree to which I can fully enter into the relationship and offer my congruence, unconditional positive regard and empathy. This applies to groups as well as individuals. The possible limitations and scope of the research are therefore intricately bound to my abilities as a person during encounters within the research process, and to my performance as a participant observer in the activities of the three study groups.

Since Rogers, more recent advocates of the person centred approach have successfully applied it to research as well. As Mearns (a person centred researcher) states "this philosophy can be seen as offering a set of values and ideas which can be usefully applied to research as to therapy" (Mearns & McLeod 1984). As with an ethnographic methodology great importance in the person centred approach is placed upon reflexivity of the researcher. It is important to state that as the person centred approach involves being oneself as a person (congruence), this means that every individual brings their own individual meaning to the approach. Therefore when I write about the approach I do not intend for it to be taken in any

dogmatic sense, it is in fact what the approach means to me. Consequently, the authors views that I choose to cite in my work are used because I identify *my meanings* in theirs.

The person centred approach places much emphasis on the quality of the relationship between people. Wolter-Gustafson (1990) - a feminist person centred researcher - states "the quality of the research depends upon the quality of the living relationship between those engaged in the research." An integral part of the quality of relationship comes from the existence of equality. It is important that a person be met as an equal in whatever enterprise is being pursued, no matter what the situation, and that it is recognised that person will have his or her own perceptions, feelings and preferences.

In addition to equality, the quality of the research relationship is to some extent dependent upon those involved obtaining sufficient rewards. My rewards as a researcher are intrinsically connected to my learning process during the research. It could be argued that if the process of research provided a growth promoting climate for research participants, then it might also provide sufficient rewards for them. As is discussed later on in this chapter, some respondents when interviewed used the interview as a counselling relationship, and the skills that I have gained as a counsellor outside of the research setting were used by the respondents in respect to the subject matter. Thus we both gained from the experience, as I was able to gain a much deeper quality of material to use in my research, and if the research relationship provided a true growth promoting climate, then the respondents may also have got some therapeutic value from the relationship.

Another important justification or reason why I selected an ethnographic approach is that unlike most positivist methodologies, ethnographic research does not occur in a linear form of hypothesis, experiment and conclusion. This was very important for me because I became involved in my field before I had formulated the ideas for the subject of a PhD or even the idea of doing a PhD. So in terms of the people and the groups that I have researched, I became involved at a time when I was still finding my way around, and I could not control the way

the way in which events took place to suit my research agenda, all I could do was fit my schedule around what took place. This has meant some aspects of my research have occurred at not always the best possible time, but the methodological approach allows for this. As Agar (1980) states in his book *The professional stranger*, typically, ethnographic research starts with a fairly wide view of the subject and then as a theory or understanding of what processes/interactions are going on is developed, the focus can then be narrowed. This allows for a much more integrated processes involving theory and method, this has been very helpful for me in enabling me to look at the processes that I am researching (public health movement formation and identity, and sense of place) and then evaluate what methods within my methodological framework I can employ to investigate them more fully. For some, particularly researchers within a positivist tradition, discussions of research methodology were concerned with identifying particular steps or stages through which the research passed from start to finish. In contrast, researchers who choose to focus on research as a social process refer to a series of processes that occur simultaneously throughout a research project, for example gaining access, collecting and recording data, and reporting data. In order to engage in all these processes a number of different methods must be employed.

## 3. Methods[3]

One of the most important aspects of fieldwork within this approach is gaining access to the groups to be studied. It is at this point that there is a need for reflexivity on the part of the researcher. Dress, appearance, class, accent, ethnicity, gender and age, as well as a number of other variables will have great effect on how the researcher is perceived by the group (Lofland 1971). The importance of reflexivity is not to overcome these factors, but to acknowledge the part that they play in the interaction and to incorporate them into the research process, this is where ethnography as a methodology greatly differs from other methodologies. As Cornwell (1984) found, it becomes apparent early on that as you establish relationships (both personal

[3] See Appendix C p 313 for additional material on methods employed during this research

received increases. I found it easier to establish relationships with people who had a similar background to me, for example I had better relationship with those who were also middle class, and who had experienced the same degree of education. Similarly there were also aspects of my person that created barriers with these same people, for example, the fact that I am Asian, made it difficult for some of these people who shared in common my class, and education, but not my ethnicity, to talk to me about issues of race.

Researchers have often indicated that their reasons for deciding to carry out a particular piece of research is because they have felt that there was a need for that research, that they would be filling a gap in the market. However, this may be an over simplification, many research problems are chosen to reflect the biography of the researcher e.g. Stacey (1976) on her study of children in hospitals admits that part of the decision for her subject material was the experience of being a mother of young children, as well as her sociological background. However, it is not enough to locate a study in a personal area of interest or experience, there have to be some other theoretical and methodological issues to help create the *academic* study. For example in researching the new public health, my interest in health developed over a number of years led me to the subject, but is fused with my geographic perspective developed in my undergraduate degree training, thus helping me to identify and develop a relevant methodological approach in order to carry out the research.

The main criticism of ethnography is about the way in which respondents are selected for interviewing, unlike positivist methods, the sampling techniques are likely to be non-random or non-probability methods of sampling. Studies show that sampling is often dependent on who the researcher has made contact with, and which respondents are willing to be interviewed. Often the people selected for interview are based on the researchers opinion of who the key people are or are obtained through what Honigman (1982) termed 'snowball' sampling, where one interviewee passes the researcher onto another informant. Donovan (1986) points out that this method of sampling is well known in anthropological work. Sampling within ethnography often leads to the use of the case study or a limited number of

cases. This is the approach taken in this study where a number of cases were selected both in the groups to be researched and the people to be interviewed from the groups. It is also possible to interpret the whole research project as a case study of the new public health.

When sampling techniques are non-random there is often criticism over the representativeness of a small number of cases studied in detail. Case studies have however been part of social research for a long time. As Mitchell points out (1983), all the American sociological journals used to carry sections purely on case studies, when social science underwent a shift towards more positivist methods and techniques closer to the natural sciences the case study became obsolete. The advent of computers meant that it was possible to carry out large scale surveys which previously had been time consuming. As Mitchell points out the case study as a section was dropped from the relevant journals.

The case study approach also has roots in medical science where an individual case is used to develop a more general theoretical statement. The background knowledge that is also gained helps to raise the level of importance of the case study. And as Mitchell stated the extent to which generalisations may be made from case studies depends upon the adequacy of the underlying theory rather than on the case itself.

As Donovan (1986) points out the interpretation of cases involves some simplification of the complexity and detail present in the data. A major advantage of the method is the depth of knowledge it gives the researcher of particular social processes. As each case is examined it can be compared to the theory being developed by the researcher, when cases appear that do not correspond to the theory they can be examined in more depth, and the theory may remain with an exception, or the theory may be changed in order to incorporate the new case. The importance of the case study lies in the appropriateness of the theoretical framework and the context of the research.

Participant Observation

One of the key research methods within an ethnographic approach is participant observation. Again participant observation involves a great deal of reflexivity on the part of the researcher in terms of how their participation is affecting the group being studied. Participant observation has often been criticised by those from within a positivist approach as being non-scientific and not sufficiently objective, but as Eyles (in Eyles and Smith 1988) points out, the application of participant observation led to the questioning of the objectivity of the researcher in all research activities.

In participant observation the participation of the researcher leads to the researcher becoming a methodological tool (See Schwartz and Jacobs 1979). There are four possible roles that a fieldworker may adopt in participant observation - complete participant, participant as observer, observer as participant, and complete observer. Junker states (1960) that the "practising field worker may well find his position and activities shifting through time from one to another of these theoretical points; even as he continues observing the same human organisation" (p38) The participant observer needs to be aware that these roles may occur simultaneously throughout the research process and that different roles may be used in the same situation. In the course of this research, the roles taken on have been primarily as participant as observer, where I was involved in activities on behalf of some of the groups in quite specific roles, such as being the secretary, and representing the department of public health. The roles of complete participant and observer as participant have also been taken on; there has not really been as occasion where I have been purely an observer. However, as Burgess (1982) states, participant observation is characterised by the relationship that exists between researcher and researched. One of the most well known and widely cited remarks about participant observation comes from Becker 1958:

> "The participant observer gathers data by participating in the daily life of the groups or organisations he studies. He watches

> the people he is studying to see what situations they ordinarily meet and how they behave in them. He enters into conversation with some or all of the participants in these situations and discovers their interpretations of the events he has observed."
> (Becker 1958 p652)

In other words participant observers are required to share the lives and the activities of those being researched, and to take roles which are effective in that setting. More importantly they are required to learn the language that is used in the setting so that they can enter into conversations and understand the ways in which important elements of the group's culture are transmitted. It is for this reason that a lot of the literature on participant observation focuses mainly on roles and relationships, rather than on the actual practicalities of participant observation i.e. how to do it - this is probably due to the fact that there are no hard and fast rules on how to interact with a group. There is not only one way of doing participant observation as there is with some positivist scientific methods.

The essential advantage of participant observation remains that the researcher as a member of a society or community has access to participation in social phenomena which in itself constitutes a method. This approach was developed from Weber's use of the concept of Verstehen, i.e. the researcher understanding what is going on in the researcher's mind/actions. It is the concept of verstehen that developed into what is now termed reflexivity or reflexive explanation. There have been some criticisms of reflexivity in research, for example Wolff (1964) argues that just because the researcher is aware of their input into a particular setting and how they have changed does not necessarily mean that they understand the process in others. This is where interpretation comes in and the researcher must formulate theories whilst undertaking the research, i.e. fusing theory and method. Participant observation relies heavily on the skills of the researcher, and this means there are no objective techniques which can be employed to assess the consistent quality of the data. Thus data quality can vary throughout the research process.

There have been questions about how you verify and validate research carried out by participant observation due to the interpretive and reflexive nature of the process. But as Eyles argues in Senses of Place, "participation is in essence really only the refinement of the methods that are used to interpret every day life. Therefore the measure of adequacy of the situation/people researched is the success of the participation by the researcher in the collective contract of the everyday life being studied" (Eyles 1985).

The participant observation carried out in this study was in the form of attending and taking part in the meetings set up by each of the three groups under study, and in other related activities of the groups such as sub-group meetings, 'homework' and correspondence. In addition to the three main groups, participant observation was carried out with two other related groups working on health issues[3], and also within the Department of Public Health within Tower Hamlets Health Authority. Gaining access to the groups was relatively easy, on registration for my PhD I became attached to the Department of Public Health as they were funding my research. Both the Spitalfields Working Party and Globe Town Health action Area had asked for a representative from this department, for which I volunteered. I had already been a member of the Health Strategy Group, as I had been invited by a previous Chair who was a lecturer when I was an undergraduate. As a result of my involvement with these groups I was later invited to participate on the management committees of a number of other projects including the Health Bus, the Tower Hamlets Health Project and the Gate Project.

Within each of the groups a formal organizational role was taken on. Within the Tower Hamlets Health Strategy group the roles of minutes secretary, secretary, and treasurer were carried out in successive years, as well as being a member of the executive committee. Participant observation was also carried out in the management committees of the workers for

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[3]The Tower Hamlets Health Project and The Health Bus Management Committee

the group. Within the Spitalfields Working Party the role of Chair and Secretary was rotated, and also participant observation was carried out by being involved with the workers management committee. In the Globe Town Health Action Area the roles taken on were not so formally identified, but included being the delegated representative from the health authority, as well as being part of the management/steering group for the worker. Being placed within the Department of Public Health was a useful introduction to a number of related people on a local, national and international level, regarding Healthy Cities, Health For All, and the new public health, as access to conferences and meetings were granted on the basis of being a member of that Department.

Taking on 'roles' within each of the groups enabled a much more comprehensive understanding and involvement with the way that the groups operated. It also meant more access to written documentation, and informal conversations, compared to what was presented at the 'formal' meetings of each of the groups. Good relationships were built up with the group members, as membership was established over a long period of time before registration for the research of this thesis, which enabled a trusting and communicative relationship to be established. The recording of information was done by writing up meetings and conversations in a diary, which was kept throughout most of the research period. Figure 2 outlines my participation in each of the three main research groups, along with when the groups began, national and international events, and important or significant events and activities. Figure 2 also outlines the period of fieldwork forming the basis for this thesis.

There were some difficulties in being a participant observer in the groups, the main problem that I encountered was becoming too involved in the activities. Because I took on roles within each of the groups and within the Department of Public Health itself, I naturally had specific activities that I had to carry out. These activities sometimes conflicted with my own perceptions of how the groups should be progressing. In order to try and overcome this I tried to act as fully as participant as I could, and then tried to evaluate my own input in the same way that I was examining the input of other members of the groups.

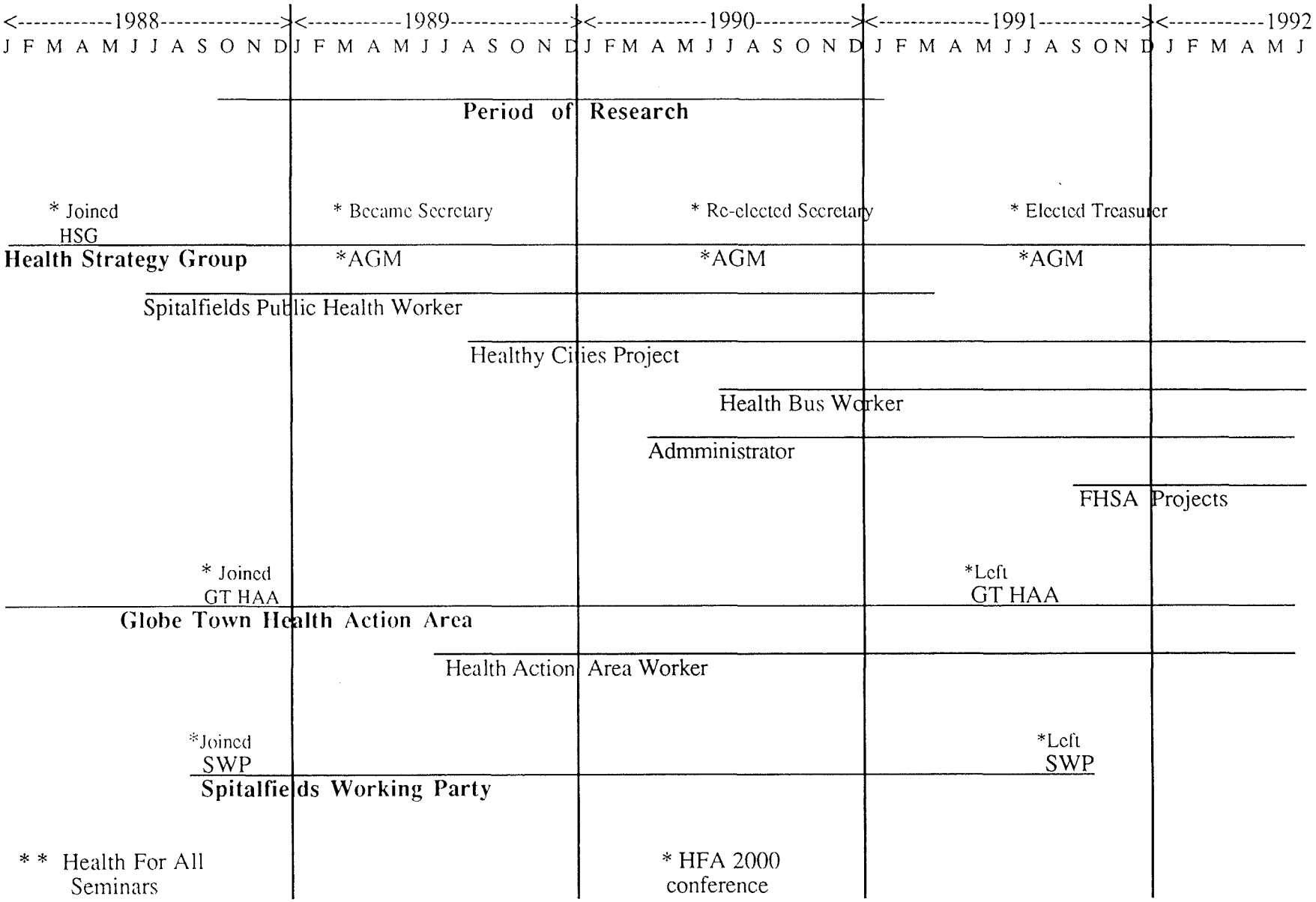


**Figure 2 - Outline of Group Activities and Researcher Involvement**

In having specific tasks to perform such as writing minutes or managing workers or participating in recruitment of staff, I became aware of the influence I had in the direction that the groups took. Again, this was dealt with by acting fully as participant, and then taking a step back to evaluate my activities. The links that I had with the Department of Public Health meant that I was a 'useful' source of information for the groups, particularly as two of the groups obtained money from the Department with my help during the research period.

Other problems encountered during participant observation included the fact that I became involved - as would be expected - with the group dynamics. I had affiliations with certain members of groups more than with others, I became part of the social network of the Health Strategy Group in particular, and I was perceived to be part of the core 'clique' of the Health Strategy group. The close associations and ties that I had built up with individuals within the groups as well as the support that I had for particular initiatives and projects meant that when I came to interview participants who disagreed with my point of view I had to try to not let this interfere with my interview technique, by writing down my feelings after each interview. The purpose of this was to acknowledge my feelings, and to attempt to 'let go' of them. The next section deals with this issue further.

Interviews

In addition to participant observation, it was decided to record personal accounts of the issues affecting the groups, opinions about Health for All and the New Public Health, and how the groups operated in practice. This was done by depth interviewing, using a tape recorder. The interviews became an important method of data collection due to the personal information, views and accounts that were entered into. As Palmer of the Chicago school stated, the importance of verbal communication cannot be underestimated in field research:

"The ability of the objects of social research to converse with each

other and with the scientific investigator is so vital a characteristic of the subject matter of social sciences that it can not be disregarded in any well rounded study.....The conversations of human beings are an important part of the data of social research as well as an important part of social research techniques."
(Palmer quoted in Burgess (1982) p107)

A depth interview is where social interaction on a particular topic which is under research is carried out and recorded. Depth interviewing is normally associated with a limited number of topic areas to be covered and not a set of rigidly defined questions to be asked. The term depth does not refer to the length of time that the interview takes, but to the different levels of material presented by the respondent, below the superficial answers. Any interview where the subject matter is decided in too much detail beforehand is not really depth interviewing (Jones 1985).

One of the main problems often raised about depth interviewing is researcher bias. This can be dealt with in the same way as all ethnographic techniques, and means the researcher must be reflexive about the interview situation and that an analysis of dialogue and language must be entered into. Because of the person centred approach taken by this researcher, the process of reflexivity was given great importance throughout the research process. Depth interviews although noted as being unstructured, are in some ways structured in the sense that there is a framework that exists within which the interview is conducted. Unstructured interviews are flexible but they are also controlled. The researcher has to keep the interviewee relating experiences/thoughts relevant to the subject under study. Platt (1976) writes about interviews which are non-directive in this way, in that they allow informants to take the subject of their discussion in whatever direction they prefer. An integral part of interviewing is becoming part of the social and cultural environment of the people you are interviewing, and sharing the same language. This may involve preparatory work on the behalf of the researcher (Strauss 1968). In the case of this study the preparatory work and experience was

gained by participant observation and involvement in the groups' activities over a long period of time.

Another form of interviewing often utilised is the group interview. Much of the research using the technique of group interviews has been on educational research, particularly with children, a good example being Osler's "Speaking Out" (1989) or Burgess et al (1988a, 1988b). These interviews are useful in terms of the informant being able to discuss ideas with other people from within the same setting or background, but can also mean that people may be more protective about what they say in terms of criticisms, or voicing a different opinion to the majority in the group. This is one of the main reasons I decided against a group interviewing technique, as I wanted to create a supportive environment for those respondents who wished to voice an opinion different to the mainstream of the group.

Another important aspect of interviews is the way in which peoples language and accounts of events vary with whom they are talking to. Cornwell (1984) states that during the interview process, as people's relationship changed with her, their accounts of the same events changed, for example, more personal information is often given as the relationship becomes stronger. I found that I had much better interviews with respondents that I had known for a longer time, or with whom I had developed a good personal relationship, and similarly I also found that my interviews were often quite difficult to carry out with people whom I had a poor relationship. The longer interviews tended to be with people with whom I felt I had a good relationship.

The interviews that were carried out for this research consisted of 16 tape recorded interviews with representatives from each of the groups.[4] The interviews varied in length from half an hour to two hours forty-five minutes. As discussed earlier in this chapter the methodological approach taken in this research seeks to recognise the personal involvement of

[4] Appendix A provides some contextual background information about each of the respondents.

the researcher in the research process, and thus also in the interviewing. Therefore although there were themes that were more relevant to the study, no attempt to lead the interview was made other than the normal progression of a conversation. In order to select the respondents I made a list of the members of each group, whether they had a particular role in the group - treasurer, secretary or chair, how long they had been involved, and whether they were attached to the health or local authorities, the voluntary sector or local community. From this list I then decided to interview all the people who held a position or particular role, all the people who had been involved for a long time, and I also tried to ensure I had a mix from the statutory authorities, voluntary sector, and from the local community. Everybody that I approached for an interview accepted.

At the beginning of each interview the respondents were told that I was interested in discussing their involvement with their particular group(s), and their views on public health. Twelve out of the 16 interviewees covered all the topics that I had wanted to cover. Out of the remaining four, the interviews were only partially useful, in that the depth of discussion needed for the research was not always attained. Had there been a more formal interviewing technique it is possible that these interviews would still have been less useful than the others, as these respondents tended to display less knowledge and enthusiasm. Three of these respondents were people with whom I had a poor relationship, in that two were relatively new to the groups and therefore we had not had much time to develop a personal relationship before being in the fairly intimate situation of an interview. Also two of the respondents interviewed were not attending the groups on a voluntary basis, they obviously disagreed with the way the groups were run, the objectives of the groups, and the fact that they had to attend, and thus we had a difficult relationship. Even though this 'disagreement' was not verbalised in the interview situation, our experiences of one another in the groups, and the non-verbal communication (for example body language) during the interview, made evident the differences and thus led to a difficult relationship and interview situation, yielding little information. It should also be noted that there were also interviews with similar difficulties that did yield the information I was after, even if I disagreed with the interviewee, and as such

the interviews were useful. All the interviews were transcribed in full, and notes were also taken after the interviews on the personal interaction, and social environment of the interview, these notes were invaluable when interpreting the comments people had made, and were also an integral part of the process of reflexivity.

It was apparent from the interviews that (as Cornwell (1984) found) much more personal accounts of attitudes towards the groups, perception of the members and work undertaken were given than were normally voiced in meetings. A number of the interviewees used the interview situation as a counselling relationship; as a chance to air some of their feelings previously unshared with other people, and as an attempt to gain validation of their thoughts. This meant that in some cases the transcriptions of the interviews read as very negative towards the groups, but in general meant that much more honest thoughts were expressed by the respondents than those who were not as trusting, and therefore not as critical. In the interpretation of the interviews I have tried to give context to particular statements, especially if I thought that they were said to me in the context of a counselling relationship, where the interviewee was discharging particularly powerful emotion. In general most of this type of information was too confidential to use in the research, as it tended to refer specifically to other individuals and their personal characteristics or specific incidents, and I felt that in the cases of these particular incidents I could not ensure anonimity if I repeated them, even though the material was complementary to this thesis. In addition, all the participants were given a chance to edit the transcripts of the interview in case there was information that they did not want to be used, during this process those who did want to edit their material removed much of the information that was very 'emotionally charged' or personal .

Projective Techniques

After working with the public health groups for a short period of time I was aware that most of the activities were concentrated in a small number of particular geographical areas that

the members of the groups appeared to know well, and that had particular meanings for them. It was also at this time that I was re-introduced to cultural and social geography, via a number of discussions held in an informal seminar series in my geography department. Concepts of place, and how place gains meaning for individuals and how those meanings are mediated by groups to achieve a group meaning or sense of place held great interest for me. So I decided to explore whether there were definite senses of place held by the groups, and if so whether their meanings had any particular relevance to public health, to the relationship between public health and the environment ,and in particular to the activities undertaken by the three groups.

In order to investigate the importance and relevance of sense of place to public health initiatives in Tower Hamlets, in addition to the participant observation, two sources of data were used. First, material on sense of place was extracted from interviews carried out, and secondly, specific exercises on perceptions of Tower Hamlets were set up to be completed by a sample of respondents from each group. It became apparent that it would not be possible to answer the questions I had relating to sense of place by participant observation alone, and that some form of focussed data collection would be needed, as participant observation would not allow me to examine the sense of place of the respondents in detail. It was decided that if the opportunity arose during the first set of interviews, an attempt would be made to make some preliminary enquiries about place and how it is viewed by those people working around public health issues in Tower Hamlets. However, it was not possible to guarantee in advance, to be able to discuss place with every respondent due to the nature of the person centred interview technique, in that no attempt was made to lead the interview.

Ideas of sense of place did arise in some of the interviews, and the subject was approached from cues given by the respondent. A cue was taken to be any mention of the respondent's perception of Tower Hamlets, from this it was possible to try to elicit further information on the respondent's image of the borough or particular parts of the area. The interviews highlighted the need for further investigation into the experiences of place of both the groups and individual members of those groups. It was apparent that in order to gain information

about peoples experience of Tower Hamlets as a place, and their perceptions of Tower Hamlets as a place, a more structured interview process was needed than had been used in the first set of interviews.

The new method of data collection had to incorporate the premises of person centred research, but it was not possible to interview in the same way as before, as it was apparent the interviewer's perceptions and experiences of place would be likely to directly influence the people being interviewed. Whereas with the interviews, an analysis of the text of each interview from the transcriptions allowed greater reflexivity, and examination of the interviewer's role, it did not seem that this would be possible to do the second time, in a manner where the interviewer could remain completely detached and not influence the descriptions, or the accounts of place that were given by the way questions were phrased, or the interpretations drawn from the mention of particular places. The interviews were carried out in an unstructured way so that the respondent could not be led, but could lead. It did not seem possible to pick a place to talk about, without having first to give a description, which would be explained in terms of the meanings I attached to the place, and therefore the respondent would be led.

The second reason for deciding not to interview in the same way as had been done for the first set of interviews was based on the analysis that would be needed. In order to keep wholly within a person centred framework, respondents should have been given the opportunity to choose their own place description. This would have made it very hard to make comparisons between the different respondent's views if there were a variety of place descriptions. Another problem would have been in trying to interpret people's descriptions or constructs of a particular named area, as the analysis would be heavily influenced by the researchers impression of the place that was being described. In addition, in trying to analyse the text of a description of a place, the analysis would be carried out from within the framework of the researchers own perceptions of that particular place. The argument is not that this would have been wrong, given that the researcher was reflexive about their input, but

that it would have been hard to make comparisons between different people's interpretations of a variety of different places.

At this point it was obvious that in order to be able to compare various accounts/perceptions of place, a number of places would need to be defined without the location being known to me, and that the best way of having an image of a place, that could be used for each respondent and remain the same, would be in the form of photographs. However, it would not be sufficient to interview the respondents using the photographs, without a little more structure, in order to elicit the information needed, while avoiding the bias of the researcher's interpretations.

The most appropriate method of collecting the data seemed to be some kind of projective technique. In most research settings respondents can usually ascertain or infer certain things that are expected of them from the researcher, and may respond by acting the 'expected' roles rather than being genuine. Projective techniques aim to take this element of trying to 'do the right thing' away from the research process. This is often done by asking the respondent to carry out an unusual activity and then followed by a request for them to interpret or show the significance or meaning of the task to them, this in turn reflects the interests and feelings of the respondent, and hopefully rules out stereotypical answers that the respondent might have been tempted to give (Branthwaite and Lunn 1985).

Projective techniques also aim to break down some of the barriers caused by all types of social interaction which are naturally present in most forms of research methods. There are five essential aims that all projective techniques have in common:

- overcome self-censorship and self-consciousness
- encourage expression and fantasy
- change perspective
- inhibit rationalisation and cognitive responses

- encourage expression of personal emotion

(Branthwaite and Lunn 1985).

For the purposes of the research conducted in this study it was necessary that the technique selected covered the first and last two aims of projective techniques listed above. This was because it would be hard to use a projective technique that covered the second aim as the technique would be basing the structure around photographs. Examples of projective techniques that have been used include word association, psychodrawings and doodles, idealisation and fantasy solutions, and role playing. There has also been work using analogies and metaphors. None of these techniques gave the ideal structure for this investigation, but the insights offered by 'personal construct theory' and 'repertory grids' were helpful.

Personal construct theory has its origins in psychotherapy (Kelly 1955) and has offered geographers a way forward in terms of forming links between image of the environment and behaviour (see Harrison and Sarre, 1971). When linked to the use of repertory grids not only does personal construct theory place individuals' personal constructions of environments in a pivotal role in the understanding of human behaviour, it also proposes a flexible and individually sensitive method of examining those personal constructions.

Repertory grids and personal construct theory have been used in many spheres of human geography and include studies of neighbourhood, urban images and retailing environment. The theory behind personal constructs is based on how individuals observe the environment and set up conceptual models to help in their own understanding and explanation of the events, and the processes that they are observing. This can be done by arranging features of the environment as it is perceived by the individual into bipolar scales, which express meaningful contrasts for that individual. It is because these scales are created on the basis of each person's individual experience that they are called personal constructs. As Harrison and Sarre point out " the poles of the constructs are taken to be psychological opposites, though

the verbal interpretation given by the subject may indicate that they are not necessarily logical opposites" (Harrison and Sarre 1971 p 366). One of the most important factors about personal constructs is that each construct has a narrow focus and does not apply to all elements of the perceived environment that the individual has, this is what makes them so useful as a tool to find out about particular aspects of the environment. Personal constructs have most often been used with repertory grids.[5]

In carrying out the research it was felt that asking the respondents to create personal constructs around a series of photographs would give a framework within which to analyse their perceptions of Tower Hamlets as a place. It was also felt that there was a need to compare the responses of respondents in order to look for any patterns, but this could only be done on the basis of individual analysis, rather than using repertory grids which would be making a judgement about the results expected, before starting the work, and would be going

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[5] In its most basic form the repertory grid consists of (usually) three elements or pictures in which the respondent is asked to compare and contrast and to rate against constructs. This information can be arranged in a matrix with values being ascribed to the constructs and to the elements. There have been two main criticisms of why repertory grid studies did not take off in the way envisaged that they would, firstly because the discussions surrounding personal construct theory became highly theorised in the late 1970s and had a high level of abstraction and therefore what had previously been seen as a useful practical tool to collect data then became part of a theoretical discussion particularly surrounding recording the scores for the matrix (Hudson 1980), and secondly while there were many studies that employed repertory grid methodology to measure environmental images, few studies explicitly related those images to behaviour, which had been the original aim of the development of the repertory grid.

against the person centred approach to interviewing and social interaction that are held as part of this researchers personal values. The result was that personal constructs were used, and tape recorded and analysed in the same way as other qualitative interview sources. As well as getting the respondents to make personal constructs around the photographs, a series of questions relating the photographs to their living and working environments were also asked.

In addition to examining people's sense of place and their perceptions of place, it seemed necessary to examine what their knowledge of Tower Hamlets was and whether this made any difference to their perception of Tower Hamlets. In other words to investigate whether greater knowledge of an area led to a more acutely defined sense of place, or whether sense of place was not reliant on detailed knowledge of an area. In order to do this some kind of projective technique was needed that could analyse their knowledge of Tower Hamlets, as well as asking them about their constructions of the borough. This was done by devising a timed exercise, where respondents would be asked to place photographs on a map of Tower Hamlets. The map would show the neighbourhoods of Tower Hamlets as well as having categories of 'don't know' and 'out of Tower Hamlets'.

The map exercise, and some of the other questions that it was necessary to ask the respondents, meant that some of the individual expression I had hoped to gain by using a projective technique was beginning to be lost. Particularly with the map exercise, the respondents could be trying to get the exercise 'right', especially in front of other people present and the researcher. It was not felt necessary to put the respondents in the position where the power was held by the researcher in terms of knowing the identity of the photographs, and whether what the respondents were saying was a 'right' or 'wrong' answer. The objective of the exercise was to get their perceptions, their abstract thoughts, therefore it was necessary for them to do the exercise using as much of their sub-conscious as is possible when fully conscious, and this could not be achieved if they felt that the interviewer knew that there was a 'right' answer.

In order to maintain objectivity it was important that I (as the interviewer) did not know where the photographs used in the study were taken, so that not only would I be unable to know where they should go on the map, but would also not be able to select images of Tower Hamlets that had significance for me. Similarly this problem needed to be overcome for the photographer. The final result was that neighbourhood maps of Tower Hamlets were obtained, and using a random number table to ascertain grid references, the location for each photograph was selected. Some of the neighbourhood maps covered areas outside of Tower Hamlets, and so there was a possibility that some of the photographs were not taken in the borough. There were approximately the same number of photograph points selected from each neighbourhood map. A total of 92 photographs were taken, 37 black and white photographs and 55 colour ones.

The reason for taking a mixture of photographs in black and white and colour was to see whether the differences in colour made a difference to the exercises and people perceptions. It was also felt that as each neighbourhood has a distinct identity by the colour of its lamp-posts, litterbins, signposts etc. it would be a control factor in the map exercise to have some photographs in black and white.

In taking the photographs the photographer was quite limited as to the precise subject of the photograph. However, it was decided that the photographer could decided the angle at which to take the photograph, the exposure and the speed. The photographer tried not to include in the pictures obvious markers such as street names, housing block names, or business names that included addresses.

When taking the photographs the photographer noted where each photograph was taken, and in what order. Once the photographs had been developed the photographer then numbered the photographs randomly, so that photographs with sequential numbering were not necessarily near one another in space. These numbers were then placed on the neighbourhood maps at the location of the photographs, this was not given to the researcher

until after the exercises were completed. Thus only the photographer knew the location of the photos until the exercises had been carried out with all the respondents.

As there were 92 photographs the sample had to be cut in order to be manageable in the interview situation. Again, this had to be done in a random way to avoid selecting photographs which had particular meaning or significance for the researcher. A random number table was used again, and for each interview a selection of photographs was taken, so that none of the respondents had exactly the same photographs as another. From piloting the exercise it was decided that 25 photographs could be handled adequately by most people for generation of constructs. The content of 25 photographs is actually more than most people can remember, however the sample had to be large enough to give respondents a variety of choices for their constructs. The sample of 25 consisted of 15 colour photographs and 10 black and white. The final interview schedule can be seen in appendix B.

For the map exercise another random number table was used to take a sample of 60 photographs for each interviewee. In this sample of 60 photographs, 24 were black and white and 36 were colour. The photographs that had been selected for both the selection of 25 and then the selection of 60, were used in the questions about what it would be like to live in those areas and which of the photographs had some relevance to their work. Using a different random sample of photographs for each respondent meant that many of the photos that were used by more than one respondent could be used for comparison.

As part of the piloting of the exercise I became the first respondent to carry out the exercise. This helped to clarify the exercise, as well as making me aware that it was possible to influence people, and that I would have to be strict about giving the same instructions to people as they were interviewed. A total of 14 interviews were carried out with a total of 18 people. There were 12 interviews with individuals, and then 2 interviews with two groups of three. The groups interviews were done with the community health workers of the Health Strategy Group and the Physicians of the Department of Public Health. The other interviews

were conducted with members of the Health Strategy Group, the Globe Town Health Action Area and the Spitalfields Working Party. Five of the respondents had been interviewed in the first set of interviews, and two of the other respondents' predecessors in their current posts had been interviewed; the other interviewees were interviewed for the first time in this exercise. A total of 11 women and six men were interviewed. The average length of the interviews was 1 hour and 15 minutes, the shortest interview was 50 minutes, the longest was 2 hours and 35 minutes.

Each interview was taped, and then the tapes were transcribed. In addition to the tape recording, notes were taken to ensure that a record of the correct photographs that the respondent was looking at was made. For the map exercise a recording sheet was used to write down in which category each photograph had been placed. Respondents were also asked to state whether they lived or had lived in Tower Hamlets, and if so for how long and in which neighbourhood. They were also asked these questions in relation to their work.

Being set a number of tasks to do is quite a threatening situation for some people, and is reminiscent of the 'exam' situation. It was therefore very helpful to explain to each respondent that I had also carried out the exercise and, more importantly, that I did not know where the photos were taken. The most reassuring statement made was that none of the exercises had a right or wrong response, and that answers would vary among individuals. However, despite trying to make the exercises as relaxed as possible there were four respondents who appeared particularly nervous. Three respondents asked whether they would "receive their marks back", and in the map exercise, a number of respondents, made comments about how difficult the exercise was and how they knew they were getting lots wrong, comments that could act as an excuse for any 'errors'. However, for the purpose of this exercise it did not matter whether respondents had placed photographs in the correct neighbourhoods, as the reason for the exercise had been to ascertain their sense of place of each of the neighbourhoods.

In conclusion, a number of methods were used in this study in order to carry out the research. The methodological approach taken is one not often used in medical geography, as much of the research carried out with in medical geography is still set within more quantitative positivist approaches. The overall approach that was taken was an ethnographic one, (more recently used by other medical geographers such as Donovan and Cornwell) chosen because ethnography is essentially about interpretation, and although in essence this is not an anthropological study, the main aim of the research was to interpret the actions and activities of the groups working on public health issues in Tower Hamlets. In order to synthesize the interpretation a number of techniques were utilised, the most important being participant observation, which in itself can be a methodological approach, or part of an ethnographic approach. Participant observation helped to set the context of the actions of the group and the context for the areas of research. Further techniques such as depth interviewing and projective techniques were utilised to gain a more specific understanding of the nature of the groups in relation to their links with a new urban social movements under the new public health, and their sense of place and its relationship to the public health work that each of the groups has undertaken.

## CHAPTER 5

# PUBLIC HEALTH IN TOWER HAMLETS

This chapter sets out the context for the research in terms of describing the place of the research - Tower Hamlets, and the nature of the organisations working in public health in the area. The chapter is divided into five main sections. The first section outlines some basic demographic factors about Tower Hamlets including some social and economic indicators that are of importance and particular relevance to public health issues. This first section also describes how the local authority services in Tower Hamlets are organised. The second section outlines the structure of the Department of Public Health in Tower Hamlets, and discusses aspects of the work of this department which are relevant to the new public health. The third section of the chapter looks at the structure and organisation of the three voluntary public health groups which are the central focus of the research for this thesis. It outlines how they are organised, what the membership consists of and also describes examples of the projects they are working on. Section four looks at how the work of these groups is set within a community development framework which is an essential component of health promotion, and the new public health framework of working. The final section re-examines the structure and organisation of the groups from the perspective of group members themselves.

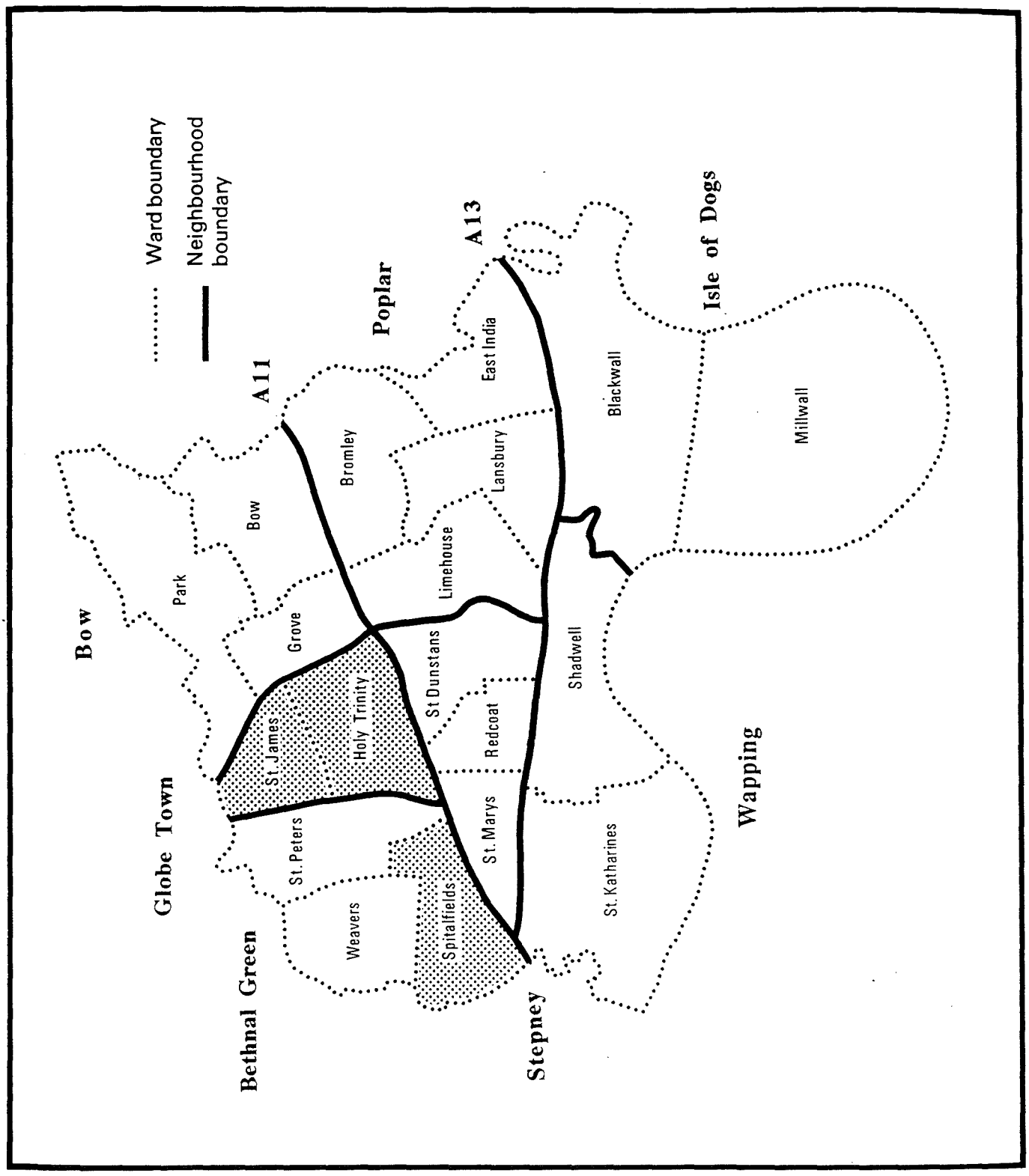
## 1.Tower Hamlets: The people and the place

Tower Hamlets is one of the 33 boroughs that make up greater London. It is the first borough situated east of the City of London. The borough covers an area of approximately 9 square miles. The boroughs of Hackney and Newham lie to the north and east of Tower Hamlets respectively, and to the south the borough is bordered by the River Thames and its

large ox-bow around the Isle of Dogs, which is instantly recognisable on any map of London (see Figure 3: a map of Tower Hamlets). There are two main A roads which cross the borough from west to east, the A11 and the A13, and nearly all traffic heading from central London for Essex, and East Anglia, travels through Tower Hamlets (Kerrigan 1982).

The borough was formed in 1963 with the merger of the former London County Council metropolitan boroughs of Stepney, Poplar, Bethnal Green and Bow. Tower Hamlets is made up of 19 wards. In 1987 the borough decentralised into seven neighbourhoods with each neighbourhood consisting of two or more wards, see figure 3. Previously all local authority services were organised centrally from different locations throughout the borough, the majority being concentrated at the Town Hall in Bethnal Green (now within Globe Town neighbourhood's boundaries). After decentralisation, services were divided into seven so that each neighbourhood became responsible for the full range of services. Funds are allocated to each neighbourhood on a proportional basis, according to the population size and number of dwellings owned by the local authority (LBTH 1987). Within each neighbourhood there is a central neighbourhood office responsible for all services from housing and environmental health to social services, and for community charges. Each neighbourhood also has a 'One Stop Shop' where local tenants and residents can go to enquire about any services, register complaints, pay rents and community charges, and receive general information on the area. Most neighbourhoods have also decentralised their housing offices to the estate based level. This means that on large local authority owned housing estates there are offices responsible for collecting rent, allocation of property, complaints, and repairs. For local tenants and residents the process of decentralisation has improved the accountability of the local authority. Tenants now have more control over services because they are devolved, and in addition formal participatory structures have been set up in the form of neighbourhood committees which are made up of local residents and councillors.

**Figure 3 Map of Tower Hamlets**



However, for many other agencies and organisations, both voluntary and statutory, decentralisation has increased their work load; this is particularly true of those who have to liaise with the local authority, because since decentralisation everything must be done seven times. If a local voluntary group wants to apply for a borough wide grant, it must do so seven times. If you want to convene a multi-sectoral meeting about a specific issue you have to invite representatives from all neighbourhoods. In practice, often not all the neighbourhoods are contacted, this can lead to initiatives only being carried out in certain areas where there is representation, particularly when initiatives are being organised by the voluntary sector. Some neighbourhoods (Poplar and Bow in particular) are rarely involved with borough wide voluntary activities, it is hard to ascertain whether this is because they are not invited, or whether they have chosen not to become involved, this issue is discussed further in chapter seven.

Decentralisation was brought into being by the Liberal council who were elected in 1986. Traditionally Tower Hamlets has been a staunch Labour stronghold, however in 1986 there was a radical shift and the Liberals took the majority vote. Two neighbourhoods remain Labour, they are the Isle of Dogs and Bethnal Green; the other five are Liberal. This division continues to cause friction, as the neighbourhoods continue to pursue different policies, particularly with regard to liaison with the voluntary sector and collaborative work. Labour neighbourhoods are much more receptive to collaboration with the voluntary sector. In terms of national politics, both local MPs representing Tower Hamlets are from the Labour Party.

The population of Tower Hamlets in 1981 was 146,000 with estimates of between 152,000 and 174,000 for 1985 (OPCS 1985). In 1991 the population was 161,064 (OPCS 1992). The population age groups that are growing are those aged 0-4, 5-14, 25-44 and those over 85, all other age groups are declining (OPCS 1985). The population in Tower Hamlets is highly mobile, with 30 percent of the population changing address every year (OPCS 1982). Traditionally in Tower Hamlets the housing stock has been quite poor, with over 82% of housing belonging to the local authority in 1981 (OPCS 1982), the highest percentage for any

local authority in England and Wales. The 1981 census also provides indicators that demonstrate the poor quality of housing such as overcrowding. Four wards had over one quarter of their properties listed as overcrowded, and Spitalfields ward is the most overcrowded in England (OPCS 1982). Many wards within the borough have almost one quarter of the housing stock lacking one or more basic amenity. Most people living in Tower Hamlets are in the social class groups 3, 4 and 5. There is high unemployment, the 1991 census records an average of 21.8% across the borough for males, compared to a Greater London average of 11.9% (OPCS 1992).

As one would expect with such a high level of poor quality housing and poor socio-economic status, the level of health in Tower Hamlets is also poor. The standardised mortality ratios calculated for the period 1981-1985, showed a value for Tower Hamlets of 160, compared to the figure of 95 for the North East Thames Regional Health Authority (Department of Community Medicine 1988). Data on social economic, and environmental factors when combined together to produce a composite deprivation index, such as the Jarman or Townsend indices, nearly always show Tower Hamlets to be one of the most deprived districts in the country. For the Jarman index, 0 is the score for the country as a whole, the lowest ward score in Tower Hamlets in 1981 was 27, the highest was 69, the highest recorded score in the country (Department of Community Medicine 1988).

Another factor particularly noticeable in Tower Hamlets, is the high number of people from ethnic minority communities. There is a wide range of ethnic, racial and linguistic backgrounds, and the area has a long history of immigration dating back to the Huguenots in the late 16th century, followed by successive waves of Jews, Irish and Bengalis (Kerrigan 1982). The major ethnic group in Tower Hamlets is White (Caucasian), the next largest group is Bengali, followed by Chinese, African and Caribbean, and Somali. Other groups represented include, Turk, Cypriot, Philippino, and Vietnamese. Data sources on the numbers of ethnic minorities are suspected to be under estimates due to an under registration on official data sources. However, other sources that have been used to get an indication of the

numbers of ethnic minorities in the past include data from the Inner London Education Authority Language census, which was carried out each year until its abolition in 1988. The 1985 ILEA census showed that Tower Hamlets had the highest proportion of children not fluent in English (31.8%) which was over twice the figure for other boroughs (12.1%). The percentage of children with a home language other than English was 38% compared with 19% for the rest of the boroughs (ILEA 1985).

Tower Hamlets has a diverse and constantly changing population both in terms of age structure, ethnicity, and class. The Docklands area has seen more change than the rest of the borough (Crilley et al 1991). Tower Hamlets is a poor area, with high levels of socio and economic deprivation, high unemployment, and poor housing. The health of the population is poor, and this is one of the main reasons for the emphasis placed on public health in the area, particularly by voluntary groups, as it is still public health measures which improve the health and wellbeing of a population more than medical intervention does.

## 2. The Department of Public Health.

Public health and Health For All initiatives and activities in Tower Hamlets, can be divided into those (services/initiatives) provided by the statutory authorities alone, and those that are provided by voluntary/community groups, sometimes in partnership with the statutory agencies. Tower Hamlets has a Department of Public Health within the health authority and is one of the few places in the country where the local authority and health authority boundaries are coterminous. This greatly helps the links between the two authorities, particularly in relation to the links between environmental health and public health, although decentralisation has weakened those links as some neighbourhood environmental health officers are more willing to collaborate over and above their statutory obligations than others. The responsibilities of the department of public health in relation to the regional and district health authorities are as follows:

- to review regularly the health of the population for which they are responsible and to identify areas for improvement.
- within the planning and review framework, define policy aims and where necessary set quantified service objectives to deal with any problems in the light of national and regional guide-lines and available resources;
- relate the decisions which they take about the distribution and investment of resources to their impact on the health of their population and objectives so identified;
- monitor and evaluate progress towards their stated policy aims and objectives including the development of indicators of outcome.

(Tower Hamlets District Health Authority, Department of Public Health Medicine. January 1989).

These activities are in addition to the activities which were listed in the section on 'the new public health'. Since the production of the white paper on the NHS, published in January 1989, departments of public health have also been involved in establishing the health care needs of the population in relation to service contracts for the district health authority to use in negotiation with providers of health care. The other important role of the department of public health in Tower Hamlets is health promotion. The health promotion activities are primarily carried out by a separate sub-department of health promotion. The work around Health For All has mainly been carried out through the research for this thesis and through the work done in collaboration with local community and voluntary groups.

One of the most important factors to note about the Department of Public Health is that is has a very limited staff, during my attachment to this department the numbers of staff ranged from six when I began in 1988 to ten (two of these staff were secretarial) when I departed in 1991. As will be shown later, the Health Strategy Group actually has more staff working on public health issues than the Department of Public Health. The reason for stating this point is not to criticise the staffing levels in the Department of Public Health, but to show how crucial collaboration with both statutory and non-statutory agencies (i.e. the voluntary sector) is for the

Department. Most of this thesis is devoted to looking at the new public health within the non-statutory sector, however members of the Department of Public Health have attended or continue to attend the three groups that are being studied. Whilst based with the Department it was apparent that nearly all initiatives were implemented in conjunction with the voluntary sector, other health service departments or the local authority. Thus, although the focus is not on the Department of Public Health, members of this Department were interviewed for this thesis in their capacity as members of the three voluntary public health groups, and the conclusions and findings relate equally to the work that they are doing on public health within the framework of the new public health.

If we reconsider the central theme of this thesis which is to examine the balance between sense of place, social movements and place as elements of the new public health, three key roles that the Department of Public Health has have direct relevance to this. The Department of Public Health is responsible for (i) assessing the health needs of the population (ii) identifying areas for improvement and (iii) implementation of interventions. Much of the work in assessing health needs is done using available data sources, and is thus what we might term 'objective'. However, a great deal of the health needs that are identified come from the needs expressed by the local community, through voluntary sector organisations such as those that are being considered in this thesis (the new public health movement at a local level). Even when health needs have been identified 'objectively' from statistical data sources, the basis on which areas are identified for improvement and intervention often are selected on the basis of the knowledge and familiarity with a particular area (sense of place) of those working in the Department of Public Health, and the influence of the community concerned whose views is also based on their sense of place. Thus we can see that sense of place and social movements are equally as important to the new public health in the statutory authorities as they are to the non-statutory authorities, and that decisions taken on behalf of the population of Tower Hamlets by the Department of Public Health might be as subjective as those taken by the public health voluntary groups also working in the area.

## 3. Public Health Groups in the Voluntary Sector

There are a variety of non-statutory or voluntary groups which carry out activities around public health, health promotion and Health for All in Tower Hamlets. Most voluntary groups working around health issues are normally working in the context of cure and care i.e self help groups around specific diseases or conditions (Alford 1975). What is interesting in Tower Hamlets is that there are a number of groups who are developing practices which are socially innovative in terms of linking social reform to political action around public health issues; the main elements of the new public health identified in chapter two.

The main groups that have been researched in terms of their input to public health and health promotion have been:

- The Tower Hamlets Health Strategy Group
- The Globe Town Health Action Area
- The Spitalfields Public Health Working Party

In addition to these three main groups, which co-ordinate most of the activities in the voluntary sector, there are a number of other groups which have had an important role in the promotion of public health and Health For All 2000, many of these are national voluntary groups with bases all over the country such as Age Concern, and MIND. There are also a number of groups in the voluntary sector unique to Tower Hamlets which are working around health issues such as the Maternity Services Liaison Scheme, the Black Women's Health Project, and the East London Homeless Health Primary Care Team (known by the acronym HHELP). However, two other groups which have a broad health remit that have made a significant contribution to public health, Health For All and health promotion in Tower Hamlets are the Tower Hamlets Health Project and the Health Bus, they have not been studied in depth as they are projects as opposed to groups working on the public health issues. Figure 4

presents a summary of the main points relating to the inception of the three main groups, the number of workers they have and their main projects.

*The Tower Hamlets Health Strategy Group*

This is the largest of the three groups and was formed in 1986 as a direct result of the Tower Hamlets Health Inquiry report. This independent report conducted into the health services and health needs of the population of the borough, was carried out by a group of independent people concerned about the poor level of health in the area (Tower Hamlets Health Inquiry Report 1987). The Health Strategy group consists of health professionals, local authority members, academics, trade unions, and community and voluntary sector representatives. There are approximately thirty five members of the group. The group has an executive committee meeting once a month, and in addition has a number of smaller groups which carry out more specific work such as support for workers, finance and administration, as opposed to the decision orientated functions or strategy of the main executive committee. The group runs a number of public health projects, there are two health promotion development projects. One of these, the 'Healthy Cities Worker' is primarily based in the neighbourhoods of the Isle of Dogs, Stepney and Wapping, and is funded by these neighbourhoods. The other project is the Health Bus Development Worker. The other three main projects employing staff are joint projects with the Family Health Services Authority: the Disability Advocacy Project (which has 4 workers: a coordinator, a Bengali advocate, and administrator, and a training and development worker); the Primary Care Users Information Project (which has two workers: a development worker and a Bengali development worker), and the Health of Rehoused Families Project (which has three workers; a Bengali development worker, a Somali development worker, and a policy worker). One project which finished in 1991, and was running during this research was the The Spitalfields Community Public Health Development worker who was

## Figure 4 - Public Health Groups in Tower Hamlets

| Name | Area covered | Started | No of members | No of workers | Projects<br>* = Projects that have now ended |
|---|---|---|---|---|---|
| Tower Hamlets Health Strategy Group | Tower Hamlets (Borough wide)* | 1986 | 35 | 13 | * Spitalfields Health Worker<br>Healthy Cities Worker<br>Health Bus Worker<br>Disability Advocacy Project<br>Primary Care Users Information Project<br>Health of Rehoused Families Project<br>* Smoking & Ramadan<br>* Access to careers in health<br>* Stress Forums |
| Globe Town Health Action Area | Globe Town | 1988 | 15 | 1 | Drugs Return Scheme<br>Golden Globes Awards<br>Health Information desk<br>Community Health Charter |
| + Spitalfields Working Party | Spitalfields | 1988 | 18 | 1 | * Pest Infestation<br>* Rubbish<br>* Housing |

The research period of this thesis is from October 1988 to January 1991. However I was a member of all three groups before the research for this thesis was undertaken. (See Figure 2).

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* This Borough wide activity in theory only, in practice the group concentrates in certain areas only. This bias is discussed in chapter seven.

+ This group ceased operation in 1991. The other groups were still continuing their activities at the time of writing - 1992.

based in Spitalfields, Bethnal Green, and worked very closely with the Spitalfields Working Party, this project was financed by the Joint Consultative Committee (health and local authority) of Tower Hamlets.

The Health Strategy Group also has a full time coordinator funded by Tower Hamlets Inner Areas Programme money, whose role is to manage the other workers and the Health Strategy group in addition to liaising with other health projects, voluntary groups and the statutory sector around public health and Health For All issues. The Health Strategy Group also employs an administrator and bookkeeper. It is one of the key aims of this group to provide workers who can work alongside the existing health and local authority professionals, yet provide services and activities where there is unmet need. The Health Strategy Group has two offices in a local community centre, and has housed the disability advocacy project in another local community centre which has better access for people with disabilities.

The Health Strategy group has been involved in a number of projects. As mentioned the Health Strategy Group (HSG) came about as a result of the Health Inquiry, which can be considered to be the first project, as the HSG was formed with the remit of following up the recommendations made, and lobbying the appropriate bodies to implement the recommendations of the inquiry. Since the Inquiry Report, the HSG has moved towards an involvement in demonstration projects, that is, where the HSG feel there is a need for a particular service or project that is not being met, they try to set up a project or service to fulfil those needs, thus demonstrating to the statutory agencies and local community possible solutions. The second major project that the HSG secured funds for was of this type, the Spitalfields Community Public Health Project. Some of the work of this project will be referred to under the Spitalfields Working Party, however, this project has carried out some activities which were not done in conjunction with the working party such as the Smoking and Ramadan project.

The Smoking and Ramadan project was a health promotion project aimed at helping Tower Hamlets' large Muslim population give up smoking. During Ramadan, Muslims refrain from smoking from sunrise to sunset. The project which was organised in conjunction with the Health Promotion department printed 25,000 fasting timetables which had anti-smoking and support messages on them, based on the message that if people could give up for Ramadan then they could give up for life. Overall the project was a great success, and was combined with health promotion sessions in one of the local Mosques. This project has now been taken on by the Health Education Authority and was instituted nationally in 1991, and included in a report by the Health Education Authority called "Take Heart - Good practices in Coronary Heart Prevention", published in 1990.

Another project which started with the Spitalfields worker and was then taken on in a much larger way in the Health Strategy Group is the 'Access to Careers in Health Professions for the Bengali community". Originally this project started off with a series of workshops held in Spitalfields for local Bengali residents. The workshops provided information on health and health related professions, the qualifications needed, access courses available, and how to make applications. The two main reasons for starting this project were firstly to encourage the local Bengali population to look for careers in health, to help overcome some of the problems associated with unemployment amongst the community, and secondly and more importantly, to try to ensure that Bengali people could be treated by medical and other health staff from their own culture who can communicate effectively, rather that continuing to rely on interpreters. Stepney Neighbourhood provided funds for a research project which was carried out jointly between the HSG and a local college of Further Education. This report came up with a number of recommendations, some of which have been taken on board by the Equal Opportunities department of the Health Authority. They include the appointment of a community personnel officer to help recruit local people and also help existing staff with their career progression. Other recommendations included changes to recruitment practices, a staff handbook, and more in-service training. The Health Strategy group is also campaigning on behalf of doctors and other health professionals who have got their qualifications overseas and are not allowed to

practice in this country. This is particularly important for the group as two of its workers are qualified doctors from Bangladesh who are unable to practise in this country.

Another project carried out by the HSG has been the 'Stress Forums'. The reason this project was set up was in response to the high turnover of staff within the health and local authorities. Tower Hamlets is a stressful environment to work in resulting in staff getting 'burnt out' after a relatively short time. It was argued that if staff were provided with the mechanisms that enabled them to help them discharge some of the stress and tensions caused by their work, this might help them stay longer, work more effectively, and ultimately improve wellbeing. A number of stress forums have taken place with 'front line' staff i.e. those working in daily contact with local residents, where a series of workshops has been run, offering different techniques of managing stress. This project has since been taken over by the community psychologist who runs regular sessions for health authority staff. The handing over of this project to the statutory authority responsible has been marked as a great success for the Health Strategy Group. A need was identified, a possible solution demonstrated, and then this was acknowledged and integrated within mainstream provision.

The "Healthy Cities Development" project in Wapping, Stepney and the Isle of Dogs, has primarily been concentrating on pest infestations. Tower Hamlets has predominantly local authority housing, in blocks of multiple units. Unfortunately when one flat becomes infected with pests (in Tower Hamlets these are most commonly cockroaches, pharaohs ants, mice and rats) they soon spread from one dwelling to another. Environmental Health have rarely been successful at gaining access to all flats within a block treatment, and thus the treatment is rarely effective. Difficulties in gaining access because of language and communication problems are the main causes for the inefficiency of the service. The HSG worker's role is to liaise with tenants, pest control workers, housing, and environmental health in both English and Bengali in order that 100 percent access can be gained. This project has been extremely successful in gaining full access to all flats within blocks. In addition to this work, the worker also carries out health advice sessions and groups on estate bases within the three neighbourhoods - these

sessions evolved from the relationship that developed between the worker, tenants, and the estate based staff.

The Health Strategy Group also has an outreach worker for the Health Bus funded by the Wakefield Trust. The main purpose of the bus is to provide an accessible place for people to come without having to travel too far, where they can feel comfortable enough to ask about any worries they may have about their own or their families health and find out more about the other health services that are available. As well as providing advice and information in the form of written leaflets and spoken information, on a variety of topics, the health bus has enabled the health visitors (who initially set up the project ) and other workers to identify areas of unmet need amongst particular clients and client groups. The role of the Health Strategy Group worker is to encourage use of the Health Bus by tenants on the estates that the bus visits. In addition the worker is involved in encouraging Bengali Women to use the bus and its facilities, and to empower them to set up other groups and facilities that they need on their estates, such as 'mothers and toddlers groups', classes in English as a second language, and health education sessions. The Health Bus Worker, like the other workers on the bus, also offers general advice and information to visitors to the bus.

The three joint FHSA projects have only started towards the end of the research period of this thesis, and as such their activities were still in the initial stages of development at the end of the research period. The Health of Rehoused Families Project was set up in 1991 to identify and reduce the long term effects of homelessness on the health of recently rehoused Bangladeshi and Somali families. It also aims to pin-point gaps in services and to help families gain access to appropriate primary care. The project has been carrying out a survey with contacts referred to them, in an attempt to identify some of the problems and issues facing these groups of people.

The Advocacy project for people with disabilities aims at increasing user control and choice in relation to quality and access to primary health care and social services. The main way of

achieving this is done through working with users, by representation, assisting, and advocacy. Finally the Primary Care Users Information Project was set up to investigate the information needs of chronically ill people between the ages of 50-64 (a group identified by the local community health council as being under served). A questionnaire has been carried out with this target group to find out what information they had access to, what they would like more of, and the forms in which they would prefer information to be given.

In addition to projects, the Health Strategy Group is actively involved in a number of networks both local, regional and national. These include at a national level, the UK Healthy Cities Network, National Community Health Resource, and the Environmental Health Network; at a more local level they are involved in a Health for All network, and Access to Employment in Health group, Community Research Network, and the Occupational Health Forum. These types of network are an important part of the work of the Health Strategy Group as they help to focus, identify and prioritise future and present work for the group.

*The Globe Town Health Action Area*

The Globe Town Health Action Area operates in the smallest of Tower Hamlets seven neighbourhoods, which had a population of approximately 16,000 at the 1981 census (OPCS 1982). In terms of having a strong identity with the statutory authorities this is probably the most formal of the three groups, as it meets in the local authority neighbourhood office, and is serviced by a local authority community development officer. In terms of membership it is also the smallest group with approximately 15 members. This group has mostly local authority and health authority representation, it has very little community or voluntary sector representation. However, it does have reasonable tenant representation. The group was formed as the result of a policy decision by the Neighbourhood shortly after its creation. The group meets every six weeks and is the most well resourced group (in terms of letters and minutes being typed) as the

neighbourhood carries out these functions, unlike in the other groups where voluntary contributions often have to be relied upon.

The group has had a worker from 1990 and although it functioned for two years without one, very little had been achieved before the worker arrived, as there was no one in the group who was able to do the outreach work needed. The group has begun to embark on a much wider range of projects since the arrival of the worker, who is based at the same community centre as the Health Strategy Group, and has an independent management group drawn from the Health Action Area.

Projects which were organised by this group before the arrival of the worker were small scale in comparison to the work of the HSG, and mainly concentrated around environmental health issues or health promotion. However these projects were important and valuable. One project which has been run for some time is the 'drug return scheme', initially set up by the environmental health department. The aim of this scheme is to encourage people to return drugs to their local chemist or pharmacy, or the local authority once they have finished with them. Another similar project was setting up points for paper collection for re-cycling.

Another successful project set up by this group has been the Golden Globes project. In this project any commercial premises selling, or handling food is entitled to apply for a golden globe award. This involves all staff being trained in food handling, and hygiene. After training is given the premises are inspected on a regular basis to see that they are maintained. Restaurants also have to ensure they are using good quality food stuffs. It is proposed to make this project more in line with the national Heartbeat award scheme, which recognises restaurants for having healthy options on the menu and no-smoking areas in addition to hygiene and cleanliness.

Another project set up by this group has been the Health Information Desk which has been based in the first stop shop of the local authority. All neighbourhoods have a 'One Stop Shop' where local tenants can come for all enquiries. The health information desk was run each

morning of the week and was staffed by various health professionals, such as district nurses, health visitors, community psychiatric nurses, as well as by people from local voluntary groups such as Age Concern. The desk provided information on all aspects of health as well as offering referrals. The desk also ran special one off events which coincided with national events such as National No-Smoking Day and Drinkwise day. This project is one of the few truly 'new public health' or Health For All type projects organised by this group, in that it has a number of aims, including increasing participation by the local community, empowerment, multi-sectoral working, and assessing needs.

The Globe Town Health Action Area is in the process of encouraging each of the estates in the neighbourhood to take on specific projects related to health, which will be managed by the local tenants committee on each estate. The Health Action Area has produced a charter which outlines the aims of Health For All and Healthy Cities, and each estate is being asked to think of target ideas which will be in line with the charter. As this project develops, it has the potential to be an important contribution to the work of the new public health, or Health For All strategy, because it is following the processes involved such as community development and participation, multi-sectoral action, equity, and consultation rather than being directive and narrow in focus.

*The Spitalfields Public Health Working Party*

The Spitalfields Public Health Working Party operates in the ward of Spitalfields. This group is serviced by the Health Strategy Group's project worker for Spitalfields. It thus has had strong ties with the Health Strategy Group in recent years, despite being in existence in one form or another for a number of years, prior to the creation of the Health Strategy Group. The composition of this group is different from the other two in that this group has the strongest tenant and local community representation of all the groups. It also has a high degree of participation from the local authority and little from the health authority. Nearly all the

representatives of the the health and local authorities that attend the Globe Town Health Action Area and the Health Strategy Group are managers, however, those that attend the Spitalfields working party tend to be 'frontline staff' who are in daily contact with the local population. This group, like the Health Strategy Group, also came about as the result of a survey, in this case the Spitalfields Health Survey which was carried out in 1984 by the Department of Community Medicine. The group in its present form was not started until 1988.

This group has been quite specific about its priorities, which were taken from the Spitalfields Health Survey. The survey asked the residents of Spitalfields to say what factors affected their health the most, the replies that had been expected were things like heart disease, smoking, unemployment. However the overwhelming majority of people listed housing, pest infestations and rubbish. All the work of the group is directed around these obvious public health issues.

In terms of pest control this group has lobbied for a pest control link worker like the HSG's link worker. The neighbourhood finally agreed in the autumn of 1989. The group maintains strong links with the local authority, and many tenants participate in the group to ensure that their complaints are dealt with satisfactorily by continued pressure on staff who attend from the local authority and health authority. As well as lobbying the local authority the group has also successfully worked in liaison with them. When the cleansing service was putting its contract for street cleaning out to tender, the working party were allowed to help specify the conditions of contract. This eventually resulted in the neighbourhood contracting to Cory-Onyx who clean the streets of Paris, instead of the Direct Labour Organisation as all the other neighbourhoods did. Cory-Onyx and the cleansing department still meet regularly with members of the group to ensure that the work is being carried out properly.

The group are producing for a second time, a card for people to place by their telephones which in addition to giving the numbers of the emergency services etc, also gives numbers for environmental health and the number for the removal of bulk rubbish. Bulk rubbish is a

problem on estates as it is often tipped off of balconies or left in stair wells. The council provides a free removal service, as long as the rubbish remains within the tenant's flat. The group is producing the cards to advertise this service.

It is very hard for the group to carry out much work around housing, as in many cases the only adequate solution is to rehouse people. However, the group is able to support tenants' groups in making complaints, and empowering people particularly those groups like Bengali women who lack power, in that within their culture they are not encouraged to voice their discomfort, and who also experience problems of communication and racism.

*Health For All in Tower Hamlets*

Unlike some health districts in Britain, Tower Hamlets so far does not have a formal Health for All strategy within the district health authority or local authority. It has addressed Health For All through various workshops and seminars. When Health For All first came on the agenda in Tower Hamlets, it was within a multi-disciplinary forum, in the form of a series of seminars organised by the local University (Queen Mary and Westfield College, London University). Attending the seminar were representatives from the Department of Public Health, Health Promotion, Environmental Health, Local Authority Housing, Social services and Chief Executives, as well as representatives from local community and voluntary agencies. I participated in the seminars, as at the time I was employed as an administrator for the seminars, and it was this series of seminars that aroused my interest in public health in Tower Hamlets, and in particular my interest in the new public health and HFA 2000.

The conclusions drawn at the last seminar were that Health for All was already being practised by a variety of groups, but that their activities were not labelled as being in pursuit of the attainment of the Health for All targets. It was suggested that there was no need to create a

new structure for Health For All, and that the creation of a new structure might actually impede the work that was already in progress. Instead it was suggested that the statutory authorities should increase their involvement and participation within the existing independent projects, and that by feeding into the work being done by the community and voluntary groups, Health For All would become more realistic as an achievable goal.

As has been demonstrated in the outline of the activities of the groups, none of the groups are working towards HFA 2000 in terms of directly working towards the 38 European targets, yet all are doing work which embrace the six overall themes or processes of Health for All, and by addressing the themes, the groups are setting up the processes that will lead to the achievement of the targets. Although the groups are not working directly towards HFA 2000, the groups all acknowledge the initiative as part of the framework within which they work. The importance of HFA 2000 to the work of the groups is that it helps to focus the work of the groups and their activities, as well as creating a wider network that each of the groups feels it is part of, in local, national, and international terms.

In 1990 the Department of Public Health in conjunction with the Health Strategy Group held a one day forum to look at projects in the borough, and how these feed into achieving the goals of Health for All. A number of community and voluntary groups were invited along with representatives from the local and health authority. The day was designed to promote the Health For All initiative, and to show the participants of the day that their work did not have to be directly related to health to contribute to Health for All and more importantly, how their work under the umbrella of Health For All could together achieve the targets set out by the World Health Organisation, through the continued implementation of the processes or six major themes of Health For All.

The Department of Public Health and the Health Strategy Group compiled a list of all the activities that are being carried out and how they relate to the targets, themes and Health For All. This process and the one day forum have led to Health For All taking on a more formal

structure in the borough. However this structure is not designed to take over what is being done, but to support and complement the existing work. The most important aspects of Health For All in Tower Hamlets are that the processes of community participation, multi-sectoral collaboration, reducing inequalities, and a primary health care approach are being implemented by a variety of groups and organisations, and in this way progress towards the overall objective of improving the physical, social, and mental wellbeing can be met.

## 4. Community Development

The approach to public health taken by the three groups being studied is a community development approach to health, and this approach is an important element that links the new public health to a variety of projects. Although community development is a much used term it has many different meanings. The definition developed by Rosenthal is: "Community development is the process by which a community, defined geographically, is aided by community workers in defining the needs that it has. With the continued help of community workers, a dialogue is then entered into with the controllers and providers of services to bring about change" (Rosenthal 1983, p.122). The Health Education Authority have supplemented this definition with: "Community Development encompasses a commitment to a holistic approach to health which recognises the central importance of social support and social networks. A community development way of working attempts to facilitate individual and collective action around common needs and concerns. These concerns and needs are identified by people themselves, rather than being imposed from outside." (Health Education Authority 1988). The Research Unit in Health and Behavioural Change advocate that one of the most important aspects of community development is in learning about the culture of the community. They state that it is "the process of 'cultural synthesis' which informs the basic philosophy of community development projects" (Research Unit in Health and Behavioural Change 1989,

p.121). From each of these definitions it is apparent that the basis behind community development as an approach to community work is an understanding of the community in terms of its structure, culture and composition, and facilitating the community in expressing its needs. This can be seen in contrast to the community development work carried out during the late nineteenth and early twentieth centuries, particularly in the colonies where values and objectives were imposed on the community from outside (Rosenthal 1983). Community development also involves an understanding of the political and administrative systems that are in place, and the skills needed to tackle these systems and organise projects. (Baldock 1974, p.3).

Community development in the U.K has grown since the 1960s, (Rosenthal 1983), although its origins are in the activities carried out in developing countries including programmes on agriculture, sanitation and health. The numbers of community workers in this country increased rapidly throughout the 1970s coinciding with the United Nations encouragement of its agencies to develop 'grassroots' work in Europe (Research Unit in Health and Behavioural Change 1989 p120). Community development grew alongside movements such as the welfare rights movement (Rosenthal 1983), and the women's movement (Research Unit in Health and Behavioural Change 1989), which generated a more widespread concern with health and health issues. By 1969 even the government had become interested in community development and formalised the community development approach with the setting up of 12 community development projects in areas of urban deprivation, where major slum clearance was underway. Du Sautoy (1966) points out that the government was not aware that community development is both an approach as well as a plan of action, aiming to promote personal growth of the participants as well as achieving the overall aim of the project, and thus these community development projects were not as successful as those which had longer term strategies and aims in mind. It is the long term aim of community development projects to "enhance the interest, competence and participation of marginalised groups in the processes of government" (Research Unit in Health and Behavioural Change 1989, p.121). A community development approach is now advocated by most people involved in health

promotion, and is an essential element of the HFA 2000 and Healthy Cities initiatives, and also of the new public health movement.

Perlman (1976) characterises the social movements of the sixties as mass movements mobilising around a variety of national issues. The civil rights movement, the welfare rights movement, the anti-war movement, and the women's movement all challenged basic assumptions about the way the country was governed and demanded changes in national policies. The seventies movements however, Perlman perceives as grassroots associations springing up out of the disillusionment with the ability of government to improve the lot of the ordinary people. The rise in community development has come about as a result of people feeling the need to act for themselves, rather than lobbying the state to act on their behalf, and this was particularly true of health groups, who were involved in campaigning against cuts in health services. Instead of defending the services that were being cut they started to examine what improvement could be made to both health services and health of the local community, and it was in this context that some of the first community development health projects started. (Research Unit in Health and Behavioural Change 1989, p122.)

The three groups under examination in this thesis are all working within the community development approach, the Health For All strategy is also based on a community development approach, as is the new public health movement. It is within this context of a community development approach that the new public health can be considered to be an urban social movement, progressing from the movements of the sixties and seventies characterised by Perlman (1976), as protesting or lobbying movements, to a movement that is trying to change the socio-economic and political environment, which is one of the essential elements of a social movement.

## 5. Public Health Groups in Tower Hamlets - The View From Inside

In order to examine the public health activities in Tower Hamlets as part of the new public health movement, a more detailed analysis of the groups selected for the research must be carried out. The primary focus of this section is not to present a reading of the situation of the groups in terms of the textual information that is available, but rather to understand what interpretations are given to each of the groups by the participants involved. It analyses how individuals from each of the three groups perceives various attributes that the groups have; the analysis is sub-divided into three parts. The first part looks at membership, representation and participation in the groups; the second concentrates on the communication and collaboration the groups have with outsiders and amongst themselves, as well as looking at the recognition and accountability that the groups have. The third part of this section looks at how members of the groups view the range of initiatives and activities that they have carried out which were described in section three of this chapter. The analysis is set within the context of the literature on urban social movements.

### Membership, Representation and Participation.

Great interest has been placed in the literature on urban social movements and participation in movements on why people are attracted to join a movement (Freeman 1983, Castells 1983, Butcher et al 1980). This section examines the membership, representation and participation of individuals within the three groups; how the group members view participation, and what encouraged them to participate, what they think about the membership of the group and how representative the group is of the local community. The most obvious starting point is an examination of the reasons that attract people to participate in a group, and what their first impressions of that group are. These questions are important to those writers who favour the resource mobilisation approach to the study of urban social movements, and are an important part of the analysis of this thesis, because the motivation

for joining the groups helps us to see what values the participants place on the groups, and what they expect to get out of being a member, which in turn highlights what is important about the movement. In any society only a few people are active participators and they are generally unrepresentative of the population. When we talk about community participation, we are probably only referring to a small minority of the actual community who are involved in the activity or group. It is accepted that participation by the whole community, even on important issues that affect every member of a community is extremely unlikely. The important question to be addressed is why people participate. Herberle (1968, p107.) stressed that individuals joined urban social movements because they were prevented from attaining their own goals which led to aggression, as a result they were "apt to find release by participation in a social movement which may direct aggressive tendencies at conditions or groups which are not responsible for the initial causes of frustration." A number of other approaches followed this psycho-analytical approach stressing that individuals are more rational than collectives, and that those people who join movements are deprived or aggressive. However, this approach came under attack, and evidence suggested that participants in social movements were neither irrational nor psychologically less stable than non participants; this criticism led to the resource mobilisation approach.

The resource mobilisation approach viewed participation as one of the many resources mobilised to create the complex movement and also suggested that people participate due to being goal orientated and that they act as rational beings who are maximising their abilities. There have been a number of criticisms of this view, not least the fact that not all work carried out by an urban social movement is goal orientated. Writers interested in the importance of human agency stress the importance of altruism, whereas others have placed emphasis on the cost/benefit of participation. Most participants gain satisfaction from associating with like minded people, opportunities to assume new roles, or the status of holding a position. Participation itself also gives rise to self-fulfilment. These personal rewards balance the costs of working, usually without immediate payoffs, towards long term goals (Gross et al 1983). From the analysis of the members of the groups, it appears that

these factors have varying degrees of importance, and that there is no single factor which accounts for why the members of a group participate. In the interviews undertaken some respondents were quite clear about why they participated, because they felt that *"the group could make a difference to life in Tower Hamlets"* or for others because *"it was expected from my manager that I should take part"*. However, for most people the reasons for participation are a result of a combination of factors which change over time.

An issue raised by a number of respondents[1] was whether each of the groups had adequate or appropriate representation/participation from the local community/population that the group serves. The Health Strategy Group (HSG) and the Spitalfields Working Party (SWP) were most concerned with the issue of representation of the local community:

> **G**:*"it is still the people who have the communities interests at heart who participate rather than the heart of the community"*.

This quotation aptly captures the feelings of a number of respondents, and the following quotations are further examples of how important it was for respondents to state that their membership was inadequate. It is important to note that those people who mentioned the issue of representation tended to occupy work roles where this was also an important issue:

> **B**:*"We need more local residents, we have a few but we need to focus on how to get people from the actual community, not the community workers"*.

> **G**:*"The glaring omission is that there aren't Black people who have claimed it as theirs, and see it as theirs, and that is true of most institutions"*.

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[1] See Appendix A for contextual information about each respondent

**J**:*"When you are doing funding applications and you have to write down ethnic origin of members, you can see we are not representative".*

**H:***"It should really be a working class led group in Tower Hamlets, but we have to look at what it is".*

Thus a great importance is attached to being seen to be representative, and this is an issue that regularly features in the minutes of two of the groups (HSG and SWP), but less regularly in the Globe Town Health Action Area minutes, particularly when approaching annual general meetings, or funding application time. Representation is seen to be particularly important around the issues of race, class, and gender; groups are eager to be seen to be promoting equal opportunities. What is interesting is that a number of people who do attend the groups in a professional capacity are also local residents, but are not perceived as residents because of their professional status. Similarly, there are members of the groups who hold professional positions, and hale from working class backgrounds, and still consider themselves to be working class, yet who are considered middle class by others, because of their professional status. The groups hold an image of the residents of Tower Hamlets that does not correspond to the image presented by some of those residents of Tower Hamlets who do attend the groups. The image of a 'typical' resident is one of a white working class, uneducated background, yet many of the residents who attend the groups are often well educated (having attended further and higher education), and in professional occupations. A few respondents also pointed out that although the groups were not necessarily representative there were reasons for this.

**G:***"It feels like the right on thing to say is that the membership is totally not right and that it should be much more grassroots and it is not reflecting the community, and in a way that is true, but given the remit,*

*I think it would have been incredibly difficult to get grassroots involvement at the start."*

**A**:*"I was surprised that it wasn't more representative but I should have expected that because they were people who could achieve and get things happening, but I still felt that there could have been more community involvement."*

**O**:*"representation could be addressed, but I also think it has to work in the way it does, to get the job done."*

**B**:*"There are obviously some really good people in the group, and people that I feel I can learn a lot from.....Having said that it inevitably strikes you as being very white and professional based even if that is voluntary sector."*

These statements illustrate how certain members of the groups acknowledge that the groups are not representative of the community they are trying to mobilise, but that they consider that the way in which the groups are structured means that this is necessary in order to function. When talking about representation, respondents all referred to the groups as being separate from themselves, nobody said 'I am not representative of the people of Tower Hamlets'. This is obviously a difficult thing to say, yet, to be representative is to be inclusive, and to have a reason for participation, to admit being unrepresentative would be excluding oneself emotionally if not physically. Conversely none of the respondents actually used the term representative in the context of their own reasons for participation. This may imply that the respondents do think that they are representative, or that they would rather not address their own reasons for attending, even if to themselves they acknowledge they are not representative. Most of the comments made about being representative and describing it as an issue for concern came form the Health Strategy Group members.

What is not made clear from either group minutes or interviews, is why participants feel that more accountable representation would lead to greater inefficiency or reduced effectiveness in the group. This raises questions about power relations amongst the members, and also about the issues that the groups are addressing. For example, if the groups were more representative, then it might be necessary for them to change the way in which they are operating, or re-focus some of their activities, and question their aims. This may be interpreted as too much trouble, particularly if the group is perceived as being successful as it is. For example, in one of the groups, there is one particular (local resident) member who often questions the direction and activities of the group, and in the absence of this person, the rest of the group comment on how they impede progress by asking too many questions, however one respondent when being interviewed commented on this:

> **E:** *" say with ..... who says some very interesting things, at one meeting I noticed ..... asked a really interesting and important question, but everybody just shut off, because ..... does tend to go on, and what was said was never taken on board and was not minuted".*

Often members of the group who hold a minority view or position are over-ridden by the more active members, who tend also to be the more articulate, educated and middle class members of the group. Many writers have noted this disparity between movements acting on the behalf of working class people, but consisting mainly of people who come from middle class backgrounds. This is particularly true of the Globe Town Health Action Area, and the Health Strategy Group. As Baine suggests:

> "While the main resource is seen as deprived or working class people they need a stimulus for action and this stimulus comes from the middle class community activist who brings to the situation an ideology and certain skills in understanding the existing state of affairs

and in explaining ways in which he thinks this state of affairs might be changed" (Baine 1975, p87).

Another topic mentioned by a number of participants were barriers to participation in the groups :

**B**:*"Because the areas that they live in have such major problems it is difficult for local people to see a long term strategic role, that makes them want to get involved"*

**M**:"*A lot of people don't participate as fully as they could, because they don't understand the jargon that is used."*

**A**:*"I get the feeling that in order to be taken seriously and get recognition the group has had to be conducted in that way, it's had to be able to attract people who have some authority within the various structures and that invariably means that ordinary local people are not going to feel comfortable in it, and really you have to be in the know already to feel that you can participate."*

The main barriers to participation mentioned by the participants concern the absence of knowledge of the topics and language used. Many of the participants involved in these groups are also involved in similar activities in their paid employment, and thus the terminology and knowledge associated with the activities of the groups are familiar to them. Another barrier to participation that was mentioned by some of the respondents was a barrier in the form of feeling excluded, or not being included in the group's discussions and activities:

**A**:*"I still feel quite on the edges, that there is a core group who are*

*looked to for sorting things out and carrying things on and I think it is quite difficult to break into that and because of that I don't feel confident enough to really be getting my head around where the group should be going."*

**J**:*"People say things about the group outside, but when they come to the meetings they say nothing, they come because of their various commitments, because they have to sometimes, but they don't say anything - what is the point in having a group if you've not got all members participating, and you've just got one or two directing it.?"*

**I**:*"Certain members of the group feel ignored, and they have said outside of the group 'there is no point me spouting off because when I do it's not taken on board.' "*

In all three groups there are dominant characters who tend to take on a lead role in shaping the groups focus of attention and activities, there are also members whose enthusiasm leads them to take on a more active role, and both these types of participators are able to gain centre stage at the expense of other less dominant, less enthusiastic, or shy people. The dominant participators tend to make and present decisions in such a way that it is difficult for other members of the groups to disagree. These members are often perceived as being aggressive or in a position of power outside of the group as well as within the group. The enthusiastic participators generally differ from the dominant participators in that rather than push the group into a certain direction, they take the direction and then come back to the group to inform them what they have done.

However, in most group situations, there will be leaders, and followers, and these are roles that need to be carried out. As Butcher et al point out " in most groups, different members have different skills and expertise and the de facto leadership oscillates between

individuals depending on respective relevance to the tasks in hand." (Butcher et al, 1980, p188.) This was demonstrated by the view of one respondent who felt that there were no real barriers to participation, and that if the motivation was there then participation could be achieved:

> **K:***"If you are concerned and you want to get involved then you get involved regardless of who you are and what background you come from."*

However this view ignores the fact that many people in the groups feel marginalised often because of their ethnicity or gender which makes them marginalised in wider society, and the same oppressions and oppressors are present in the groups. Interestingly, in the Health Strategy group it tends to be men who feel marginalised as the group has a predominance of actively feminist women.

Many participants also talked about the fact that many of the people involved with one group were also involved with another, sometimes acting as a representative of the same organisation, and occasionally participants wear 'more than one hat' to the various groups they attend. This can lead to interesting comparisons in behaviour, when examining how people behave according to what organisation they are representing in terms of what they are prepared to say, what resources they are prepared to commit, and what they are prepared to criticise. As one member put it:

> **I:***"Sometimes I don't know what meeting I am at, because it is always the same old faces that you see."*

Another respondent made the comment:

> **H:***"When anything new crops up, like formulating a new organisation*

*you find a lot of people already involved elsewhere will be contacted to find out if they want to be associated with this new particular group."*

There is a core group of 'active campaigners' that exists in Tower Hamlets, normally around particular issues like housing, education or health, and whenever a new campaign or group is formed to tackle the issues these 'key' people are always called upon to become involved. Often the involvement of these people is used as a lever to attract others, and to give the groups credibility. The fact that many people participate in more than one group, may also be a barrier to participation for others, because they feel there is a monopoly on the group leadership. Also the fact that people get to know one another at more then one group, and perhaps socially, may also lead to the feeling that there is a core group or 'clique', again creating a barrier for other participators. Ross in his chapter in Freeman (1983) illustrates how, when a movement creates a sense of community within, the sense of community can create factionalism in the movement by causing distinct cohorts to become cliques. He argues that when new cohorts are not integrated into already existing groups they will form challenges to the existing clique. A lack of proper integration is more common among movements that are inclusive - movements that anyone can join - and that also draw from a heterogeneous population. The groups under study are all inclusive groups, when examined within Ross' terms and framework. Freeman herself also talks about cliques or elites:

"Very seldom does a small group of people get together and deliberately try to take over a larger group for its own ends. Elites are nothing more and nothing less than groups of friends who happen to participate in the same political activities. They would maintain their friendship whether or not they were involved with the group... It is the coincidence of these two phenomena which create elites in any group and makes them so difficult to break" (Freeman 1972, p4).

Freeman's description of 'cliques' is very appropriate for two of the groups under study, (the Health Strategy Group and the Spitalfields Working Party), as all the members are essentially working towards a common aim, and the cliques that are formed tend to be between those who are more enthusiastic, and willing to spend their time working for the group. Their friendship and knowledge of the issues is greater, and from the outside they appear to be a 'clique', and are sometimes considered to be trying to take over the group by other members. However, they are not necessarily challenging for the leadership of the group because of a wish to be dominant, but because of their wish to progress the work. In the other group (Globe Town), the leadership has tended to be dominated by the local authority members who have a tendency to chair and organise the meetings. They thus exert more control over the activities of the group, their motives are not always necessarily to do with a wish to progress the work so much as a need to ensure the group's activities are complementary to the neighbourhood's policy.

Collaboration, Accountability and Recognition

The purpose of this section is to examine what the participants of the group feel about their relationships with other agencies and between individuals in the groups i.e. issues of communication and collaboration. It also analyses the way in which the groups value accountability and recognition, both from the community they serve, and from the statutory agencies.

Collaboration is one of the main themes that is addressed by the WHO's Health For All (HFA) initiative, and thus is an important issue to address for all the groups. The groups do not collaborate only in order to address this theme of HFA, but because they see it as a necessary function of their activities, however HFA has helped the groups to pay particular attention to collaboration with a wider variety of groups. Within each group there are representatives from various agencies, both statutory and non-statutory, so that even at the

individual level there is collaboration. Being able to collaborate effectively is one of the most important tools a voluntary group has, and this is also acknowledged by writers on urban social movements. Collaboration is one of the issues that distinguishes urban social movements from urban protest movements, urban protest movements seek to lobby and campaign against the statutory organisations in particular, whereas social movements try and work with these organisations.

One of the reasons that voluntary groups and urban social movements are so much more successful at collaborating than other formal bureaucratic organisations (e.g government, industry or businesses) is because they do not have the same hierarchical structure, and permit internal as well as external participation, in terms of who is governing them, where they meet, and how they are organised. The health authority and local authority, often communicate much more effectively with one another through the help of the three voluntary groups who mediate between the organisations, and do not need to follow the 'formal' procedures. This is partly due to the fact that most of the representatives from the statutory authorities who turn up to the meetings, do so on a voluntary basis, and are therefore much more receptive to other ideas. From the attendance lists written in the minutes, it can be seen that representatives who are 'forced' to attend the meetings tend to drop out after a few months. Some participants also decided to attend the groups because they knew that effective collaboration would be a key element:

> **K**:*"Officially it was thought a good idea because it brought people together from different agencies."*

As outlined earlier in this chapter, the groups have a wide variety of organisations represented. The main organisations are the health authority and local authority, but all three groups also have academic representation, local tenants, community workers and trade unions. This means that they have a wide base of experience, knowledge and attitudes to draw from. Owing to the open nature of the groups, other visitors attend on a less frequent

basis, such as representatives from major funding bodies and charities, local councillors and businesses, this again widens the base of the groups.

However, collaboration is not without its problems. The voluntary sector is able to work in a very different way from both the health authority and local authority, and these in turn also operate in different ways from each other. This can lead to dissension:

> **I:***"one is also prejudiced against the way in which local government organises itself. One gets an impression of people who are fairly well meaning but can't always get their act together."*

These accusations could be placed against any large organisation where bureaucracy is unavoidable. The advantage of voluntary groups is that they are small enough to be able to get round the bureaucracy in order to carry out the activities they desire. A lot of the antagonism that comes from the voluntary sector towards the statutory sector is based on the fact that the groups are often very eager to get a project moving as fast as possible, and if liaison with the statutory authorities is a necessary part of the project, then it inevitably leads to delay. Saunders (1979) identified four typical relationships between a local authority and voluntary groups, the first two relationships - political partnership and tactical protest - are relationships where the interests of both group and authority are broadly consistent with local policies, and the second two - competing agreement and non-competing contradiction - when interests are not consistent. The three study groups in Tower Hamlets display a mixture of these approaches in their relationship with the statutory authorities depending on the issue under discussion. The Globe Town Health Action Area however, tends to operate solely under the first two relationships due to its strong local authority participation. As Saunders goes on to say:

> "Groups face the dilemma of whether to risk incorporation by acting within the system, or risk isolation by acting outside it. In reality of

course, this involves not a stark choice between two alternative strategies, but rather the pursuit of a strategy which is more or less accomodative or more or less coercive. In other words, conciliation and coercion represent polar types on a continuum, and any specific action is likely to fall at some point between them"
(Saunders 1979 p240).

Many participants in the group are also able to create new relationships with members of other organisations, that not only help them to carry out the group's activities, but also help them with their work outside of the groups. From participant observation it has been possible to see how groups use someone they know in a particular organisation when they have to make contact with that organisation, particularly when it is local government. Often someone, a known person, from another department is contacted in the hope that they will know who the 'right' person is, in the appropriate departments. As Saunders (1979) points out:

"Direct contact has proved of greater value than the letters and formal protests of less well connected groups"
(Saunders 1979. p241).

In Tower Hamlets there are additional problems of collaboration, because the local authority has decentralised its services into seven neighbourhoods as one respondent pointed out:

A:*"It is a reflection of the way that health is being divided up between health authority, social services and environmental health. So what is really inter-connected has become very compartmentalized and that becomes particularly apparent when you are working around public health."*

Decentralisation has meant that the groups working on a smaller scale such as the Spitalfields Working Party, have been able to make good relationships with key personnel. However, those groups covering a larger area, like the Health Strategy Group, have found it increasingly difficult to work. The Health Strategy Group has tended to focus in particular areas so that it builds up a network of contacts, and because it works in particular areas, it fosters the knowledge to continue working there when new projects arise. A more detailed discussion of this cycle of activities is described in chapter 7, relating to differences in activities in different neighbourhoods.

> **F**:*"the neighbourhood system is good for communication and collaboration, it is easy for people to make personal relationships, smaller scale, more local, focussed, but it also fragments work across the borough which must be very frustrating for people trying to work."*

Decentralisation by the local authority into smaller units has also led to more work for the voluntary sector in that everything has to be done seven times. For example in applying for grants to work across the borough, grant applications must be sent in to each neighbourhood (none of the neighbourhoods have the same form) which is very time consuming. Then, as in the case of one bid put in by the Health Strategy Group, it is possible that money is not received from all the neighbourhoods, which means that group is working in patches, and may not have enough money to employ a worker full time.

The problems of collaboration and communication are not merely grounded in the organisation the participant represents constraining their lines of communication. Often problems arise because of personal dislikes, or because people want to head in opposite directions, or carry out activities in different ways. Most of the respondents were fairly philosophical about these differences which were summed up by one respondent who said:

> **H**:*"When you have got a motley assortment of people, you are bound*

*to get different types of views, people who have different opinions about how they see things, and I think one should have an understanding about that and accept it for what it is."*

The fact that different participants have different views and beliefs is actually an important factor in the way that the groups work. Very often representatives from the statutory organisations are used to looking at things from within a particular framework, the wide variety of people at each of the groups helps everyone to re-assess their outlook from a different angle, and brings an assortment of ideas for new projects, and ways of working. Often people from the statutory agencies get blinded by seeing things in professional terms and are not aware of more unorthodox solutions, and those from the community can not see a way out of a particular problem, as they may not have access to key people or experience. For example in the Spitalfields Working Party, there are often very frank discussions between local tenants and council officers about the possible solutions to problems, which have led to amicable solutions that perhaps the council would not have thought of on their own accord. A good example is the members of the group suggesting that rubbish be collected during market hours rather than after the markets finished, as it prevented rubbish being spread into neighbouring areas by the wind. The mixture of people with different backgrounds, experiences and knowledge, means that the group is able to expand in a number of different directions, rather than the more conventional linear route that has generally been taken by the statutory authorities on public health issues. This multi-directional expansion, also enables individuals to flourish within the group, in a way that they might not be able to in their work environment:

**E**:*"It's not the same situation that you would get in an authority or a department where there is a hierarchy, because you are all there for your knowledge ,experience, and commitment, and your position is not important to the group, it's what you can put in, your input."*

Relationships between the group members is on a horizontal level, as opposed to the vertical levels normally found in the work place. This is important to the work of the groups and is also a key feature of social movements. Not only are relationships between group members on a horizontal level, but relationships with other organisations outside of the group are also on a horizontal as opposed to vertical level, again another key distinction of social movements. As Freeman states:

> " A movement structure that is segmentary, polycephalous, and reticulate has several significant advantages over a centralised and bureaucratic organisation or a movement dominated by one. (Freeman 1983. p117).

It is precisely the fact that the groups are able to work in different ways, that makes them a target for some people to criticise. This is particularly true of people whose paid jobs are senior ones within management structures. Some senior managers perceive some of the projects that are undertaken as being 'off-beat' because they do not follow conventional (in health or local authority terms) patterns of activity, direction and supervision. This view of their work is acknowledged by a number of the group members, and can be summed up by one respondent who said:

> A:*"Because public health is still (although it is an old field) an innovative field, but because of the image of greening and the green movement it is still kind of cranky, people do feel isolated and treated if what they are doing is a bit weird and not real."*

This feeling of the work being undertaken being perceived of as 'weird' or 'cranky' was expressed by a number of people, and was also the subject of discussion at the groups. This was particularly felt in the Health Strategy group and Spitalfields Working Party; the Globe Town Health Action Area has tended to follow more 'conventional' models. Many of the

activities undertaken are developmental and are approaching 'old' problems from a new angle; consequently they are often termed as being unorthodox. This negative interpretation placed on some of the work undertaken, particularly by people in senior positions, can be quite damaging to the groups' activities. For example, at one time members of the health authority could attend Health Strategy Group Meetings but were not allowed to contribute to them, which meant that for a long time vital collaborative links were lost. A number of respondents mentioned that when they tried to use similar ways of working or methods in their paid employment they felt isolated because it was a 'different way of working'. The factors contributing to the isolation (lack of recognition, collaboration, and communication), can severely hamper the work of the movements as these are the key to their success. But having recognition from senior management can be a double edged sword:

> **B**:*"We need more recognition from the powers that be, but on the other hand it doesn't want to be consumed by the establishment, it [HSG] needs its independence."*

The feelings expressed by this respondent, and echoed by others, are that the groups are treading a fine line between getting the support they need to enhance their activities and being subsumed by the statutory authorities and losing the innovative ways of working that they have established. It is important on both a personal/individual level and the professional organisational level that the groups get recognition. On the one hand they need recognition to help secure further funding and support for their activities and workers, and on a personal level they need recognition as a validation for the work they are carrying out. As Lipsky (1968) points out "to be successful, to create political resources by gaining sympathetic public attention, recruiting new members, and mobilising third parties as movement allies, protest groups must establish credibility with various outsiders." The members of the groups are all voluntary (apart from paid staff working for the groups), and therefore do not receive any remuneration for their activities, in fact many people donate time and resources at their own expense. Therefore there is a need for them to receive something back from their

services, for most people this consisted of some kind of validation, recognition and support. As one respondent pointed out:

> **D:***It doesn't necessarily need support from people high up, but support - we need to produce a proposal for health that would come from the community, health and local authorities, and all the groups would support it, and give commitment".*

What this respondent is demonstrating is that validation and accountability does not just come from people in positions of authority within the statutory services, but is also important from the community and local tenants that the groups are serving. The Health Strategy Group has been particularly successful in gaining support and recognition from the health authority, particularly since its rapid expansion in terms of the number of projects and workers. The health authority is now keen to liaise with the group, and for some departments - Health Promotion, and Public Health - it is seen as crucial. The Health Strategy group are seen as an important resource that complements work being done by the health authority.

All the respondents acknowledged that although it was very important for them to receive support and commitment from the both the local community and those in 'positions of power', there was still a need for the groups to keep a certain distance in order to maintain a certain degree of autonomy over their work. For nearly all the members of each of the groups, they felt it was most important that they remained accountable to the local people of Tower Hamlets, in terms of satisfying the needs felt by the community. Some of the members of the Globe Town group, felt that this was hard to do, due to the strong local authority involvement .

The groups have developed various mechanisms to try to ensure accountability. Although all three groups have open meetings in that anyone can attend, particular effort is

made by the Spitalfields Working Party and the Health Strategy Group, particularly with regard to annual general meetings, for which invitations and notices of the meetings are circulated widely. All three groups have tried to ensure that the local community is consulted about projects which are proposed, and that community views are sought in evaluation of initiatives. Formal mechanisms such as the Health Inquiry, and the Health Information Desk have provided opportunities for local people to raise issues that are important to them and thus make the groups more accountable for their activities.

A number of respondents mentioned how important it was to have local tenants and residents within a multi-disciplinary forum such as the groups, because it meant that they were able to talk to some of their service providers on an equal level:

> **K**:*"The tenants are a really useful guide to officers who are providing solutions to people who are usually faceless, the public, the punters, and it is for good for them [the officers] to be told face to face what it is like to live with cockroaches".*

However one group member expressed a sentiment felt by a number of the people interviewed, that where officers are delegated to come to the meetings, they are not really offering any service or help to the group:

> **E**:*"The perception of the local authority officers is that they are doing this group a favour to turn up as opposed to perceiving that this is the public they serve, what we have failed to get over to them, is that this isn't optional".*

In order for a social movement to be successful it is necessary that the participants attend voluntarily. Not only do participants who have been delegated not join in with the activities and work of the groups, they do not share the emotional aspects of the groups' work, the

success at achieving a project, or the sadness of failing to secure funding. The groups that have achieved most success with local authority participation are the groups that have been able to attract officers with a genuine commitment to the group, who are not necessarily attending because it was suggested by their manager, but because they felt the group(s) contributed to their professional role in their paid employment, and were also something they felt they could contribute to. The relationship between these officers and the groups strengthens as they begin to offer mutual support for one another, and develop a good working relationship. The main problem that appears to exist is in attracting these sorts of officers who have a genuine commitment of whom there appear to be very few. This problem has been experienced in all three groups, and it is mainly local, rather than health authority officers who are apathetic towards the groups and their work.

Another potential problem that has occurred with the groups in Tower Hamlets is that on a number of occasions, officers have 'borrowed' ideas generated by the groups, but have given no credit to the groups for their ideas or work. This can be incredibly disheartening for the groups, as although they achieve their ultimate aim of seeing an initiative happen, they may feel there is no validation for their efforts, there is no personal reward for the group or members involved, which is one of the key elements that encourages participation in the movement. However some voluntary groups see others within the statutory authorities taking on and owning their ideas as a success, as it means the initiative will receive full attention and support, and that infiltration of alternative ideas has been accomplished.

Another important role that the groups play in terms of collaboration, recognition, and accountability, is in providing support for one another as individuals. As one respondent pointed out:

> A:*"I know I feel glad of the group being there, that I can go and know that there are going to be people who are coming from similar places as me who will understand the work that I do and that I can link in with*

*the work that they do."*

This is an extremely important function that the groups serve in that they almost provide a counselling relationship for individual members, who receive empathy from their companions in the group. By taking on this role the groups ensure that individuals can continue to work within the difficult restrictions placed on them by the nature of the work both within the remit of the groups' activities and their formal employment outside of the group. The fact that often groups' will be attempting to work in very different ways from their colleagues within the statutory authorities, as they try to implement more developmental and innovative ideas, these ideas are often thought of as unorthodox or "cranky". The Health Strategy Group fulfils this role more than the other two groups, this may in part be due to the friendship between group members on a social level, outside of the groups' activities.

Group Activities - Success and Failure

The purpose of this part is to look at how the members of the groups view the activities and goals of the groups, what they consider to be successful and what they consider to be a problem or criticism of the group. In general there was a great consensus of opinion about what aspects of their work was successful and what was not. A number of respondents felt that the success of the groups rested on what they were able to achieve in concrete terms. In giving examples of successful outcomes of the groups' activities, most respondents tended to list one or more of the projects that were outlined in section three of this chapter, specifying an actual project. Most respondents also tended to select projects that had employed staff such as the Healthy Cities Development worker rather than projects which had no staff employed like the stress forums. Very few respondents were keen to list the discussions within the group as being a success or the networking or collaboration that goes

on. All three groups have been through a period where most meetings were spent in discussions, but with no end result. As one respondent pointed out:

> **I:***"It often seems to me that meetings are held for the sake of it whether or not there is something to discuss".*

Although the tendency to become a "talking shop" still occurs from time to time which is documented in the minutes of each group, on the whole the groups have all passed out of this phase quite successfully. Initially all the groups went through a period or phase when they were first set up, where a great deal of time was spent on abstract discussion of ideas and strategies, and also on re-stating the public health problems of the area. For two of the groups, this stage passed by employing outreach workers to start some initiatives that had been talked about for a long time (Health Strategy Group and Globe Town Health Action Area), and for the third group, the group was suspended by mutual agreement for three months and then re-convened with a new remit and focus (Spitalfields Working Party). The character of each meeting is largely determined by who turns up to the meetings. Individual members operate in different ways, some like to discuss the implications of activities and work on contingency measures, whereas others are keen to start action as soon as possible.

The way that the meetings are chaired and the way in which the agendas are set also influences the structure that the meetings take. One of the groups (Spitalfields Working Party) rotates the chair, and the agenda is also set by the group at the end of the meeting, this is done to some extent by all three groups, this is helpful in allowing everyone to participate and to put on the agenda any items that they feel are particularly important. It also serves as a useful device in allowing everyone to participate in discussions, and helps to overcome some people's tendency to turn up to meetings and not participate, and others who participate too actively. Again this relates to the un-hierarchical structure of the groups, which in turn aids their success.

When talking about activities that were perceived as less successful or problematic, a number of respondents mentioned the difficulties in working with the local authority and health authority. There was a general feeling that although there was a need to work with the statutory agencies, they also impeded the progress of the groups considerably:

> J:*"A lot of problems relate to general communication and management problems within the neighbourhood, and not to the initiatives".*

Because the statutory authorities are so large they do take more time to process information and carry out work. However, the groups themselves have also found that increasing in size also has its problems for the groups themselves. One member of the HSG recalls how the group started to expand:

> E:*"Up to now we have muddled through about accommodation, management of workers, etc, it hasn't been a big issue for us, but I am sure outside, peoples eyebrows were raised, but all of us in the HSG are doing other full time work".*

As the groups have expanded physically with new members and new workers, and needed more space, more support for workers, accounts, and legal advice, they have had to learn as they go along. This has been a particular issue for the Health Strategy Group who underwent a series of rapid expansions in 1989 and 1991. Although within the group, members were aware of the changing needs of workers and the changing requirements in resources, they were not always met in an orthodox manner, as events were managed as they happened instead of being planned for in advance. As Ross (in Freeman 1983) discusses "Social movements need to balance the desirability of rapid expansion, the capacity to respond to changing circumstances, and low degrees of structure with a sense of organisational survival and continuity". The group which expanded the greatest, and also the most rapidly was the Health Strategy Group, and it was often the short time lapse

between applying for and receiving a grant for work which caused difficulties in planning. The needs of workers were often provided for in ad hoc ways, which often did not support the workers adequately in terms of resources or emotional support, and it became clear to the group that structures needed to be in place before new workers could be recruited. This has resulted in the latest workers to be recruited having a two week induction programme, involving meeting key personnel in the local and health authorities, having names and addresses supplied of key people within both the voluntary and statutory sector, and also providing the opportunity for staff training.

The unorthodox way in which resources were supplied (often workers paying for resources from their own pocket and being refunded at a later date from the budget) and workers serviced, led to some criticism from outside the group particularly from senior managers within both the health and local authorities. There is a need felt by all three groups that they should try and present a 'professional' image when dealing with other agencies, and this has not always been possible. This has been seen as a problem from both within and from outside the group. Not only can these difficulties be seen as 'unprofessional' but in some circumstances could be quite damaging for individuals, particularly workers, who may not be getting adequate support, or a position that fits into a career structure enabling them to move on within the same field, although this is also a problem that also occurs in the statutory agencies. These issues have begun to be taken on board by all three groups, but due to the voluntary nature of the membership of the groups cannot be sorted out quickly. As Dickinson has said, "organisation is one of the most important and difficult areas in voluntary action. The form your organisation takes, and the way it is seen by the people involved, are both crucial to the continued existence and effectiveness of your group" (Dickinson 1973, p22).

One common theme amongst the participants was relating what they had thought about the group, or heard about the group before joining, to their actual experience of what the group was like. In some cases the first impressions of the group lived up to what they were

expecting, and in others, it was found that the group was very different to what had been expected. For example one member talking about the Health Strategy Group:

> **A:** *"My first impressions of the group, was that I was not clear about what its function was, I thought it would have a stronger community development focus to it.....I actually thought from things that I had read that it would have a more grassroots focus, but I think that was a reflection of the time that I joined.....anyway I think lack of clarity was my first impression."*

In this case the written material about the Health Strategy Group had attracted the new member, in the interview the participant had said that she had been feeling isolated in her work, and on reading about the Health Strategy Group, had felt that it was a place where she could find people *"who could see Tower Hamlets and Health in the same way that I do"*, but at the time that member joined, the group was not operating in the way that had been relayed in the written information, or her interpretation of that information. This need to find a group that 'thought' in the same way is one of the factors addressed by writers such as Hasson (1992) and Touraine (1985), who suggest that participants join urban social movements in the search for identity, an identity that is somewhat different to the identity that the rest of society have, as they argue that members of urban social movements think and act in a different way from the rest of society.

The fact that this respondent felt the written material she had read was misleading raises questions of how groups are able to express themselves in writing, and whether they give accurate representations, or are 'advertising' or 'selling' their activities unfairly. All three groups are very aware of the need for well written material, especially when seeking funding like any organisation their primary goal is to present the best image possible. There is also a need to target written material for different audiences, for example the requirements when writing to the health or local authorities would be different from those when writing to

another voluntary sector group. The conflict that may arise is that when a group is trying to sell itself in the market in terms of attracting new members, it may actually be going against some of its own political beliefs and ideology, particularly around issues of equality and representation, by creating an image of its activities and structure which are not truly representative of the situation. The groups fall into a situation whereby they may follow a line of action, which they have previously criticised others for, or which may go against some of their beliefs, but is felt to be the only way possible to achieve their goals.

In the last three years there has been a dramatic illustration of this potentially serious conflict for some groups, in particular those working around health issues. In 1989 when the Government announced its plans for the National Health Service (HMSO 1989), which included hospitals being given the option to operate as Self Governing Trusts, and General Practitioners the option to become budget holders, there was an outcry from many community organisations, particularly those related to health (Tower Hamlets Health Campaign 1990), who criticised the decisions as making health an issue of economics, of putting the NHS into the marketplace. However by early 1991, the community organisations forum of Tower Hamlets (an umbrella organisation for many community groups, that provides an information and mailing service to all voluntary groups) ran a series of workshops on the whole contracting process, with the aim of enabling community groups to learn the appropriate skills of negotiation and contracting in order that they could put in bids for money from the new purchasing authority. This switch from lobbying and protesting against contracting to focussing on how to become part of the process, is not necessarily a switch based on changes in ideology or political belief, rather it is a more accurate marker of the difficulties most community and voluntary groups are facing in terms of funding. For many organisations the reality is that they either participate in the contracting process, and sell themselves and their activities like any other consumer item or service, or they sink whilst protesting against the free market approach. As Saunders (1979) points out:

"The strategies which may be available to different local groups for

> pursuing their interests in relation to the local state may therefore be understood to vary along a continuum between conciliatory action (which in most cases will come to be defined as 'responsible') and coercive action (i.e. attempts to force concessions - a strategy which in most cases will come to be defined as 'irresponsible')"
> (Saunders 1979. p232).

Information about a group may also have been gained from outside observers as well as from written material and publicity, and this can also serve to raise expectations, or to influence how the group should be perceived:

> **I:***"When you go to a group like that your views are somewhat coloured by what you hear and so you do go with a certain level of expectation, and it's difficult to distance yourself."*

> **I**: *"Again a lot of perceptions were formed before I even got there from comments relating to things that the group had done."*

The way that groups are perceived by outsiders, and the way that groups are spoken about greatly affects the groups ability to mobilise participants to become involved. Some of the participants said that before joining the groups they were under the impression from other people, that the group was not successful, and so would not be a productive use of time, but had joined due to instructions from their managers, or had joined in the hope that the things they had heard were not true. This finding was true of all three groups. Although most participants who have joined the groups have done so voluntarily, the members who have been requested to attend by their managers have erratic attendance as evidence from the minutes shows, and do not participate fully when they do attend. This may often be why the impression of a group that is not successful or productive is given, because of the lack of enthusiasm and commitment by those forced to attend. A number of writers on urban social

movements, notably those concerned with the resource mobilisation approach, and writers such as Hasson and Lowe, who are concerned with the role of individual agents, have concluded that for the groups to achieve their aims, participation must be voluntary. For some (Lowe 1986 , Dunleavy 1980), an organisation where the participants are not attending on a wholly voluntary basis, would mean the organisation could not be defined as an urban social movement. However, in practice, those people who are attending on a non-voluntary basis, tend to withdraw completely from attending meetings after a few months, and therefore do not affect the way in which the groups act.

Another problem mentioned by a number of respondents, when interviewed, was the fact that a lot of initiatives were duplicating work elsewhere, however I have found it hard to find other evidence for this. There is evidence that initiatives duplicate similar ways of working e.g. a community development approach, and sometimes projects are copied from one area of the borough to another e.g. the pest infestation treatment; however, I can find no written or verbal evidence to support that work has been duplicated in full, although there is frequently duplication of certain aspects of projects. There is often a lack of communication between the statutory services and the voluntary sector as well as amongst voluntary groups themselves and this often leads to parts of project work being duplicated:

> **O:***"There is a lot of overlapping with things, and sometimes it can have a depressing effect, in reaching out too many ways it can be very confusing and by branching out too much you get less done."*

The desire to change the nature of public health in Tower Hamlets 'today', has been a problem faced by all three groups. The enthusiasm and commitment that the members bring to the groups sometimes rushes the groups into activities and events without thinking through the consequences, or without having an overall strategy or plan. There is a tendency in all voluntary sector groups to 'jump' after any money that is seen to be on offer. This happened in particular to the Health Strategy Group, who applied for a series of grants, and

to their surprise got them all resulting in rapid expansion in terms of the numbers of workers and projects. A number of respondents felt that one of the problems that they faced was in trying to prioritize their work, in that everything they looked at seemed to need some sort of attention, and thus the activities become crisis management with no input into long term solutions:

> **E**:*"What is going to be done with those posts in the long term is what is crucial, if the HSG gets sucked up into becoming a management committee, to simply have to focus on maintaining those projects, if we have a role of providing models of good practice but not wanting to take over then there needs to be something else in terms of pushing those things to be repeated elsewhere".*

> **B**:*"They are good at getting money for projects and selling them at that level, but what we don't do is then sell supporting them, we expect them to be self-sufficient. We can network all we like with the community, but we won't get any further than that."*

> **A**:*"Something that has worried me is the practical support that is actually given to the action. The group is good at setting things up but is difficult to keep them running if there is no structure,"*

Again these criticisms are a result of the practicalities of running an organisation on a volunteer basis, the fact that there is a lack of experience of how to manage projects successfully and plan for the future. Most of the work that is being undertaken by the three groups is pioneering work so the groups have had no experience of what to expect and have thus been learning from their mistakes. However the great danger is that they will by-pass the overall aim of changing the public health of Tower Hamlets by getting too involved in the day to day running of the projects and their associated problems. For some people this

represents a serious problem, in that they feel the purpose of the groups should be to work towards an alternative future vision, and that if the groups get too sucked into the present, they will lose the ability to create change - the overall purpose of an urban social movement. As one respondent said on commenting about the conflict between present and future work:

> **A**:"*But that threw up another difficulty for me, about whether the group was to be generating new areas of work or new ideas critiques, or whatever.*"

> **J**:"*although its stated aims are quite clear, sometimes it finds it difficult to see its direction, but that is nothing new it is the same with the establishment.*"

> **E**:"*People moan that it can be too much of a talking shop and too theoretical*"

This last comment points to what is perhaps one of the hardest tasks of any voluntary organisation, and particularly a social movement, in trying to strike a balance between being too theoretical and being too practical. Individual members tend to lean towards theory or practice, and it is often the arduous task of the chair to make sure that some kind of consensus is reached about the direction that the group follows, and also making sure that everyone understands the reasons behind the decisions and their purpose. One advantage that the groups have is that their non-hierarchical nature enables individuals to clarify points without feeling ignorant. As Butcher et al point out:

> "the degree of success that groups have, together with the larger question of their organisational effectiveness, are clearly of immediate practical concern to all those people engaged in trying to promote social change at the local level"
> (Butcher et al, 1980, p159).

When talking to the respondents about what they felt were particular strengths of the groups or successes, a number of issues were raised, in general the respondents were pleased at how the initiatives were local in their focus, and how they applied specifically to the needs of Tower Hamlets because they were community led. This relates back to the context of a community development approach discussed earlier in this chapter, and the quest for accountability with the local community. Another point stressed by some respondents was how the groups were able to be flexible and change according to the perceived needs, much faster than the statutory agencies. The types of comments given were:

> **J**:*"The success of the group has been the speed that it has gained and set up projects around specific issues related to Tower Hamlets."*

> **G:***"It has shifted from emphasizing the recommendations of the Health Inquiry Report, to getting on with action on the ground."*

> **B**:*"The biggest successes of the group are that it has got recognition, collaboration, and gained funding to employ people."*

These quotations all refer to the Health Strategy Group. In general respondents of the other two groups were not as forthcoming about what they considered to be a success, this was particularly evident in the responses of those members of the Globe Town Health Action Area. Most respondents measured success in terms of the number of projects or activities - the practical initiatives undertaken. Very few respondents mentioned more esoteric goals such as improved relationships with statutory authorities, greater accountability with local people, or changes in attitude towards ways of working in public health - issues that were raised by a number of respondents when talking about the less effective aspects of the group.

A lot of work which is done by the groups in terms of networking and information sharing goes unnoticed (this is particularly true of the Health Strategy Group), yet is an

integral part of the success of the groups, as is their collaboration with various groups and organisations, and the fact that their membership is drawn from a wide area. The groups provide a key role in sharing information on projects and activities between other voluntary groups and between the statutory authorities. Often the groups remain the only lines of communication between the local and health authorities particularly at the lower levels of management where there is no formal communication between officers in the health authority and those in the local authority, and no communication filtering down from senior management. No one mentioned the way in which the groups work in an non-hierarchical manner as a success, yet this is actually one of the key ways that the groups are able to attract and maintain their membership, and work effectively on difficult issues.

For some people there were doubts as to whether the groups could claim the responsibility for achieving certain initiatives, for example the Spitalfields Working Party pressure on the health authority to employ a recruitment officer for local (especially Bengali) residents. This is a project that was devised by the group and put to the health authority for implementation, however there can never be a true record of the group's influence and impact in getting this project started. This was summed up by one respondent who said:

E:*"Would these things have happened anyway without us?"*

This comment reflects a doubt that most likely crosses everyones mind at some point, however, there are in each group a number of people who have a particularly jaded view of the role of the work that can be undertaken, not because they feel it is unimportant, but because they feel the obstacles are insurmountable. It tended to be these people who questioned whether the groups had achieved anything, but at the same time these members tended to have been coming to the groups for longest, so perhaps their somewhat pessimistic views reflect weariness. However achievements were formally noted by the groups, for example the Health Strategy Group produces an annual report citing the work of each of the projects and highlighting activities, the Spitalfields Working Party and Globe Town Health

Action Area groups produced an evaluation report highlighting their achievements for their funding bodies each year. Within these written documents stress was placed on concrete activities which may have contributed to respondents seeing success in these terms.

## 6. Summary

This chapter has outlined the nature of public health activities in Tower Hamlets. The context of public health in Tower Hamlets was set by examining briefly the social and economic status of the borough. The chapter then moved on to look at the formal organisation of the Department of Public Health, and Health For All, and then in more detail at the structure and organisation of the three voluntary groups being studied. This analysis has been done both 'objectively': listing the structure of the groups; their methods of organisation; number of members; and activities; and subjectively: with the focus in the last two sections concentrating on the group members' views of these issues.

The most important points to conclude from the first section describing Tower Hamlets are how the area is extremely deprived ranking highest on composite indices of deprivation in health, social and economic terms. The process of decentralisation within the local authority has led to improvements in accountability of services for tenants, but has also contributed to difficulties in collaboration between the health authority and local authority and the voluntary sector and local authority because of the necessity to repeat everything in each neighbourhood, and ensure representation with each neighbourhood. This has particular relevance for public health issues which need to be tackled in a multi-sectoral way. There are also difficulties with the local political situation with labour and liberal neighbourhoods pursuing different policy strategies which may or may not align themselves with the policy direction of the new public health activities.

In the second section on the Department of Public Health, the small number of staff working in the department with an extremely wide and important remit was highlighted. This in turn has led to the need for members of this department to collaborate on initiatives with the local authority and voluntary sector in order to ensure that they can meet their statutory obligations. The department has extremely important responsibilities in terms of recognising the health needs of the area, and distributing resources to meet those needs, because of the need to collaborate, the department often has to rely on subjective measures of health need based on information received from the community and voluntary sector.

Section three presented an outline of the three voluntary public health groups who are the focus for the research in this thesis. The important things to be noted are the difference in size of the three groups not just in terms of the different geographical scales they are working on (borough, neighbourhood and ward), but also in terms of their membership, number of workers and projects. The Health Strategy group is actually larger than the Department of Public Health in terms of number of staff. The Health Strategy group has members from a variety of backgrounds whereas the Globe Town Health Action Area tends to be dominated by members from the local authority and the Spitalfields Working Party has high tenant representation. In examining the development of Health For All activities in this section it was apparent that very little organisation of activities towards this initiative have happened formally (the seminar series and one-day forum) however, most work on public health issues carried out by voluntary groups is set with in a Health For All framework.

Section four highlighted how the community development approach which is a strong component of Health For All and Healthy Cities and thus the new public health was the framework within which the groups are working. The groups are trying to remain accountable to the local population they serve, by tackling issues raised by local people. The community development approach has a strong grounding in the development of urban social movements.

In the final section the emphasis was put on how the members of the groups perceived their own activities and this was set within the context of the literature on urban social movements. In the first part of this section issues of membership, representation and participation were addressed. The three groups were keen to be seen to be representative, but there were difficulties in knowing what was truly representative, as the present membership does not necessarily fit with the image of a typical Tower Hamlets resident. Barriers to participation included class, gender, and ethnicity, other factors that impeded participation was the formation of cliques within the membership of the groups.

Part two of this section addressed collaboration, accountability and recognition. The members of the groups felt that there were difficulties of collaborating with the statutory authorities because of the different ways of working. The groups felt themselves to be more unorthodox and less hierarchical than the statutory authorities. Particular problems were mentioned with regard to the local authority because of decentralisation. The groups felt there was a need to be accountable to the local population but that to gain recognition there needed to be some accountability to senior professionals within the statutory authorities.

In the third part of this section emphasis was placed on the respondents' opinions of successes and failures of the groups. In general respondents identified more concrete action as being successes rather than more abstract activities such as networking or collaboration, most examples cited were of specific projects, generally those which had involved the most money. Failures were considered to be the fact that work was often felt to have been duplicated elsewhere, and also the perception that change was not happening fast enough. An issue that came up in all three sections was the need to have voluntary participation within the membership of the groups in order to ensure commitment and enthusiasm.

In the next chapter, the analysis still focuses on the perception of members of the groups, but the material is analysed to see in what ways the three study groups might be considered part of the new public health social movement.

## CHAPTER 6

# PUBLIC HEALTH GROUPS IN TOWER HAMLETS - A NEW URBAN SOCIAL MOVEMENT?

This chapter concentrates on examining on what basis the public health groups in Tower Hamlets can be considered part of the new public health social movement, and whether Health For All and the Healthy Cities initiatives are in fact part of the new public health movement. The chapter is divided into four sections. The first section looks at the theories and ideologies that govern the groups, their strategies and visions for the future. This section is important as it is this aspect of the groups - their ideology - that helps to ascertain whether they are organised in the way that other social movements have been, having a common vision or objective. In the second section the groups are looked at separately, and some common themes are addressed which have specific importance for each of the groups and the formation of urban social movements. In particular, the groups are analysed under the headings of the criteria set out within this author's interpretation of what constitutes an urban social movement that was set out in chapter three.

In the third section these themes are developed in terms of the criteria discussed by writers on urban social movements, (as discussed in chapter three) on what constitutes an urban social movement. Comparisons, and differences between the groups are also examined in this section. The final section analyses how the Healthy Cities initiative and the new public health can be viewed as an urban social movement.

## 1. Theory, Ideology and a Vision for the Future.

This section addresses some of the ideologies that individual group members share about the nature of the work, the future of the groups, and their activities. In Tower

Hamlets local authority and health authority, the staff turnover in jobs is extremely high. It is generally agreed that like most inner city areas, it is difficult to work in Tower Hamlets, and keep optimistic. In general, people who join urban social movements do so because they have some hope and optimism that they can effect a change in the way that things happen. In the case of the groups under study, they are trying to effect change in public health, and although on the whole the groups have a positive outlook, it does not mean that members do not recognise some of the difficulties that they face. The following comments show what problems members perceive with their vision for the future public health in Tower Hamlets:

> **A**:*"I don't want to be depressing but the way things are going there has to be some serious thinking about how to action progress in public health because of the financial constraints local and health authorities are under."*

> **B:***"Because there are so many problems in Tower Hamlets, and because of the pressure, the only way you get people to attend meetings is to actually give them a perception of the immediacy of the problem, anything more esoteric like strategy, or long term stuff tends to get pushed to the back, it is very tempting to deal with but the crisis has already arrived. It is fire fighting all the time."*

> **G**:*"We have got a lot further to go than many because we are starting further back."*

There is a general trend amongst workers in Tower Hamlets to get sucked into 'fire-fighting' most of the time, when under so much pressure it becomes difficult to see a way out. The movements offer members an improved vision of the future that they can work towards, and help to give some structure to over worked and over burdened employees,

particularly those 'frontline' staff based in the local and health authorities. A lot of the work that is carried out under the auspices of 'firefighting' is in fact quite positive work, however it tends to be trivialised and marginalised because it is not part of a coherent response or strategy to overcoming a problem. In some situations the public health groups may not appear to be offering a structure to the work that needs to be done, yet often the crisis that the groups are responding to urgently could not have been planned for, for example responding to health authority decisions to cut particular services, or to particular public health problems such as pollution or infestations. The image that is created of Tower Hamlets by the media, on television and in the national papers, tends to consist of reports about a decaying inner city area, high unemployment, large ethnic minority communities, under resourcing, and generally poor. As is discussed in chapter seven this is also a view perpetuated by some health workers. This poor image of Tower Hamlets, in some circumstances, can be relied upon as as excuse for failure, and it sets people up to fail, because there are some problems that need changes in national governmental policy, that local groups can not change alone. What is apparent from the comments of some respondents is that they often don't realise the significance of the activities that they do carry out. As Dearlove suggests:

> "to measure success solely on the basis of a one-to-one relationship between particular campaigns and demands..... is to ignore the significance of the cumulative, or drip, effect of all this activity" (Dearlove, 1979, p238).

One of the important issues raised by a number of respondents was the role of politics in the group's activities. The groups themselves are not overtly political in that they do not claim to be working for any particular political party, although within the groups individual members are on the local council or are members of national parties, or have a strong role in trade unions, and campaigning against the government. Although the Health Strategy and Spitalfields groups tend to have a left-wing orientation as most members support the

Labour Party's policies on health, the members do not necessarily share the same ideals. In some discussions within these two groups this has led to conflict and there are divisions as to whether politics should be brought in to group discussions in a more substantial way. In the Globe Town Health Action Area, members of the group from the local authority are not allowed to express a political opinion. The argument for being more political within was voiced by one respondent who said:

> **A:***"It has got to be put on the agenda that health is inherently political with a small 'p', and the idea that every time anything we touch on is political - which is everything to do with health - can not be part of the package, won't fit, because if you are looking at strategy and structural change which is actually what we have got to look at to be able to see a change in health status of the people, then it is in direct conflict with the overall aim of the group."*

Each of the groups has a different level of politicisation, and this greatly affects the ways in which the groups work, but what is acknowledged by all three groups is that the issues that they are addressing are greatly affected by local and national party politics:

> **G**:*"It is going to be difficult to make progress until those other huge political issues have been addressed and it will take great courage on behalf of those people in charge to shift resources".*

The local and national political system have a great effect on the way that movements organise themselves, and operate; even if they are detached from formal party politics, they can not escape the influence of the political system that they are in. As Lowe suggest:

> "The characteristics of local political systems and the existence of a range of ideologies within these systems crucially affect the

genesis of urban social movements, their tactics and organisational forms, and create the specific conditions for the growth of some movements or the absence of, or co-option of, conflict around key issues" (Lowe 1986, p81).

Within the groups there are also varied approaches to the ways that health promotion and public health should be carried out. In general there is a consensus of opinion about the strategy taken towards health promotion and public health and this consensus helps to ensure that work can be undertaken collectively. However, when interviewing, it was apparent that some members felt that some initiatives taken were too radical, while others considered them not radical enough. As one respondent said:

> **A:***"I personally have a lot of reservations about mainstream health education and I hoped for a more radical critique of health education than I have been aware of in the group, people seem very willing to fall in around heart disease and risk factors and smoking, and whilst I don't want to throw those things out completely, I think there are serious limitations to seeing health education in those terms, and that is important because it is that body of knowledge, that way of approaching improving health that can still inform the way in which the project workers do their work, and a lot of that I still believe is individualistic, is victim blaming, even if nobody is intending to do that a lot of work comes out of that tradition, out of that way of approaching health, and I would like to see a more thorough going argument for addressing the social determinants of ill health."*

This respondent was voicing the belief that the groups often tend to fall back into more orthodox methods of approaching public health work, to avoid criticism of being too radical, or too innovative. For the same reasons that the groups addressed the issues of

contracting within the NHS, they also tend to stay within the mainstream (NHS) interpretations of public health and health promotion/education, which often consider the WHO models and definitions to be radical. To stay within the mainstream interpretation causes less jeopardy to funds, support and validation, particularly from senior management level with in the statutory authorities. As Gillespie (in his chapter in Freeman 1983) states:

> "Accounts of social movements organisations often interpret the moderation of tactics and the institutionalisation of conflict as signs of growing organisational conservatism. According to this view, the adoption of more conservative tactics by a social movement organisation shows that its leaders have sought accommodation with the organisations opponents"
> (Gillespie Ch 16, p262 in Freeman 1983).

Gillespie's comments are perhaps too extreme, in that some of the reasons that the groups have to be more conservative are because that is the only way to receive adequate funding, and not necessarily because they are becoming more conservative in their overall approach. There is also the view that to generate a new or radical ideology around concrete activities would involve a lot of discussion, which would need to be more formally organised and planned. The Health Strategy Group did at one time organise a series of strategic choice workshops to help formulate their future priorities. But when talking to those who attended, the overall impression gained was that although helpful, the workshops were not as productive as the initiatives being generated by the group now towards forming an overall ideology. At the time the Health Strategy Group had no projects, and little concept of the realities of managing projects and workers, and therefore the group found it hard to conceptualise these ideas in a workshop. In the present situation, the group members feel that their experiences of the projects help to focus future action, based on experience.

The most common ideology shared by all three groups is that of the World Health Organisations Health for All by the Year 2000 initiative:

> **B:** *"If you are going to do anything on health in Tower Hamlets it has to be linked to Health for All, whether it is indirectly or directly. We need to do this to give the bones of a strategy."*

Health For All has been extremely useful to the groups in this way by forming a framework of reference, not only in serving to direct the work, but also in linking the groups together and with other areas working towards HFA. One of the interesting aspects of Health For All in Tower Hamlets, is that compared to most districts who have undertaken this initiative, there really has been no formal co-ordination by an overall umbrella or steering group, or particular individual, and this is because the view expressed below was taken on board fairly quickly, that health for all is already being 'done':

> **K**:*"I think one of the big problems with HFA is that it tends to be picked up as something new and wonderful, instead of patting people who are already doing it on the back; cause everyone at grassroots who is involved in any health or social care is actually participating in HFA activity and this needs to be got over much more strongly than it is."*

It was this view that led to a one day forum held in the summer of 1990 in Tower Hamlets to assess what action was happening in Tower Hamlets, and how this could be linked into the umbrella of Health For All. The forum was a joint initiative by the Department of Public Health and the Health Strategy Group, and was the start of a continuing process to organise the HFA process within a more strategic framework, focussed specifically towards the needs of Tower Hamlets.

When the respondents were asked about the long term strategy of their group, the overall response was along the lines of 'improving the health of the population of Tower Hamlets'; however, there were some who felt it was difficult to take a long term view or strategy:

> **I:***"The strategy to me is a bit of a misplaced word, as I don't see what the strategy is, there is no long term plan, and these small scale projects are certainly focussed at involving local people, and if that is the long term strategy, I haven't seen it stated as such, if the aim is to develop the concept of health being in the hands of the people and maximising the way they make use of the resources for their own health then I don't think that has been clearly stated."*

The respondent who gave this quotation had been asked to attend the Health Strategy Group by their manager from work, and did not enjoy participating in it. During the course of the interview the respondent said that they did not see a purpose for the work, or the group, as Tower Hamlets was beyond repair. This respondent has since left to work elsewhere. However, the comments given should not be negated because of the respondent's pessimistic attitude, because, to a lesser degree the sentiments of the above statement were echoed by other respondents. Some other comments that were given include:

> **K:***"I am not sure whether the group is in a position to develop strategies, it will have its own strategies for its own aims but it is a little pretentious to have a strategy for health care for the whole of Tower Hamlets on the basis of a collection of small and not wholly representative people."*

> **E:***"I don't think they are a very forward strategic group, I think they are*

*very reactionary, 'look we've got to do something, we've got to get the group credibility, let's do something to say the group has done this'."*

It is interesting to note that the respondents who gave the above views, have all left Tower Hamlets after relatively short periods of time. A conclusion that can be drawn from this is that for one reason or another they were obviously unhappy with the situation, and perhaps did not share the same beliefs as the public health movements in Tower Hamlets. Their departure is also significant in that they did not hold a vision of the future to work towards, which could help mobilise them into action within the new public health movement and ideology.

In the interviews the respondents were asked about their ideal for Tower Hamlets, and their views were surprisingly similar. In general the ideas expressed were what would happen if the things that they had earlier criticised were missing. For example, to improve Tower Hamlets, most people felt needed improved collaboration, long term projects, and improved resources:

**K**:*"If we had the ideal situation we would have a situation where each neighbourhood would be doing there own thing and would send a representative, and you would get a strong local authority input, and cross fertilisation of ideas."*

**A**:*"A lot of mainstream provision started as voluntary innovative work, and that for some of the public health workers, what we are aiming for is that the health and local authorities will provide those workers as a matter of course, and that we will let people go and encourage the mainstream authorities to take them on on long term contracts."*

**O**:*"Information and communication are the keys to effective work they create the power, but also create problems as well, and so therefore they are the barriers to achieving as well as the mechanisms for success"*

It is a necessary function of all urban social movements to have some positive view of the future to work towards. What was interesting amongst the views expressed was that although most respondents had ideals for the future, they were to a certain extent grounded within reality, i.e. they were to a large extent achievable within the next decade, as most were based on the present activities of the group. Other writers of social movements have spoken of utopian dreams of members that can never be achieved. Perhaps in Tower Hamlets, the prevailing ethos of 'doom and gloom' expounded by both the local people, health workers and the media, leads people into lowering their expectations, or shying away from raising them too high, in case they are never achieved:

**H**:*"As long as I live here I will have some involvement. But you have to be realistic. It is certainly not going to solve all your problems, but if we get limited success it will be a step forward."*

The alternative interpretation may lie in the fact that the targets that are being set are realisable, and thus ensure progress is made. Within the interview situation respondents may have felt reticent about describing a 'utopian' dream for the future, which they felt to be un-achievable, and therefore they stuck to recounting more realistic objectives. Another factor is that some of the respondents had acknowledged the need for wider social change in national governmental policies on health, education, employment and housing, which are out of the sphere of activities of the groups. However, as part of the new public health and healthy cities movements, these wider macro targets, which aim to influence policy at a national level are potentially realisable.

Despite the fact that the targets for the future that have been set in the minds of the members of the groups are quite low, the one overwhelming consensus of opinion was:

**G:***"as always the voluntary sector will lead the way."*

The general belief is that the diffusion of ideas and action spreads from the voluntary sector down to the statutory sectors, that the voluntary sector is innovative, creative, and dynamic and that the statutory services, are conservative, solid, and lack imagination. It is this belief that generates participation and momentum for the movements, and makes them complementary to the organised state system of provision.

## 2. Individual Characteristics of the Groups.

The purpose of this section is to look at the three groups in turn to see which of them can be interpreted to be part of an urban social movement, or a local expression of the new social movement of the new public health. Up to this point all three groups have been considered as being urban social movements, but when looked at separately it can be seen that from the definition outlined at the end of the section on the theory of urban social movements in chapter 3, only one of the groups is a true urban social movement. The four key elements stressed at the end of that section were: the common aim of the members (in trying to effect change); the voluntary nature of participation within the group; the importance of democracy; and the pluralism of group members. The Health Strategy Group is the only group that really meets this criteria of being an social movement, the second could be considered an urban social movement, but operates on a small scale (the Spitalfields Working Party), and the third group does not meet the criteria (the Globe Town Health Action Area). If we examine each of these groups under the headings, it is possible to see how they match up.

Common Aim of the Members

Although to some extent all three groups do have a 'common aim of the members' in terms of their conviction in the new public health, for the Globe Town Health Action Area, a number of disparities arise. Because of the strong local authority representation on this group, the group is pushed into carrying out activities that promote the local authority in a positive light, and adhere to the council's policies. For example in Globe Town, any initiatives started on one estate must be followed by similar initiatives on the other estates, whether or not they are appropriate for that estate. For example, a programme set up to teach Bengali women English using Health and Health Services as the topic to learn the language was implemented on all estates, despite two of the estates having no Bengali families on them. The Globe Town Health Action Area is also strongly persuaded not to get involved in politics at the national or local level, and the following quote (also in section 4) was specifically said about Globe Town:

> **B**:*"It has got to be put on the agenda that health is inherently political with a small 'p', and the idea that every time anything we touch on is political - which is everything to do with health - can not be part of the package, won't fit, because if you are looking at strategy and structural change which is actually what we have got to look at to be able to see a change in health status of the people, then it is in direct conflict with the overall aim of the group."*

This refers to the fact that anything that has a political message as deemed by the council cannot be used; for example, any information about cuts in spending on health cannot be used. This conflict in attitude produces difficulties in the group, and often causes tensions between the health authority staff and the local authority staff.

Although the Spitalfields Working Party does not have the same kind of conflicts about its overall direction as the Globe Town group, a number of the participants who are in the group are not there for the common good of the area of Spitalfields, but rather for the good of their particular estate or issue. In general their competing priorities do not lead to conflict within the group, and on major issues, all do pull together to achieve success for the whole area. However, it might be considered that the group as a whole does not share as cohesive a common aim as the Health Strategy Group does. In addition the aims are set much lower, and tend to be directed towards the achievement of specific projects rather than towards achieving a particular level of health for the community.

The Health Strategy Group shares a common aim of trying to improve the public health of the area of Tower Hamlets. Most of the representatives who come do so because they have a borough wide interest. The Health Strategy Group also has greater independence than the Globe Town Health Action Area, which means that no one group (health or local authority) has control over group decisions, and thus of all the groups, the Health Strategy Group most shares a common aim.

An examination of the minutes and participant observation have shown how discussions in each of the groups are very different depending on whether the group has a common aim. The discussions that take place in the Globe Town Health Action Area are very reserved in comparison to the other groups. One reason for this is that the participants from the different sectors are aware that they look at health in different terms, and that no amount of discussion will influence another party to change their ideas, particularly with regard to the local authority.

Participation

The next area to be assessed is the 'voluntary nature of participation'. The Globe Town Health Action Area has the poorest attendance of all the groups. Although it circulates the

minutes/invitations quite widely (to 28 people), there have never been more than 14 people who have attended. Nearly all the representatives from the local authority who attend (which consists of two thirds of the group) are delegated, and as such, some of these officers tend to be less than enthusiastic for the meetings and work of the group. Attendance is extremely erratic, with officers attending on the behalf of other colleagues without knowing anything about the group. There are some local authority officers who have remained with the group since its inception, who put in a great deal of effort into the group. These also tend to be the officers who gain most reward from the groups activities in terms of help with their work for the council. Because the group took a long time to achieve any concrete action, a number of health authority personnel dropped out arguing it was an inefficient use of their time, and the group has since found it difficult to recruit new members who have perhaps heard 'defamatory' remarks about the Globe Town group. At the time of writing there are only two representatives on this group who were there at the group's inception. As one respondent said when asked about his perception of the Health Action Area:

**I:** *"the group composition has changed every time I have been there."*

So once again, it is not possible to say that the Globe Town group wholly meets this criteria.

The Spitalfields working party in general tends to have voluntary participation, but occasionally has had delegated representatives from the local authority attending. There has been mixed response from these delegates; some have got involved with the group and stayed, whereas others have had an erratic attendance, but on the whole the group is well attended. The fact that it has been running in one form or another for almost ten years is testament to the commitment of the membership.

The Health Strategy Group has almost all voluntary representation apart from the workers employed by the group. There were at one time a couple of officers from the local and health authorities who were designated to come, but who dropped out within six months; all other participants come of their own free will. This can be seen from the enthusiasm and commitment given by group members, particularly when it is considered that almost all members hold full time jobs in addition to the work that they do for the Health Strategy group. Thus the Health Strategy Group seems to satisfy this second requirement.

Democracy

The third part of the interpretation of what constitutes an urban social movement is concerned with the 'importance of democracy' within the groups. This refers to the way that the groups organise and run themselves. The Globe Town Health Action Area is the least democratic of all three groups. The meetings are held in the Neighbourhood Offices (local authority), which means that they are not in a neutral location, and this might be quite intimidating, particularly for local people. The meetings were at one time chaired by the Chief Executive of the local authority and are now chaired by one of the local councillors. Although it is good to have commitment from high up, the high status of these people can be a deterrent to others to participate. Also the fact that officers attend, and the meetings are being run by their line managers, makes it difficult for them to participate fully.

The Spitalfields Working Party is perhaps the most democratic of all the groups. The Chair and minutes secretary are rotated each meeting, the agenda for the following meeting is set the previous month, and a great emphasis is placed on everyone being encouraged to talk at the meetings, and to present any issues as an item on the agenda.

The Health Strategy Group is also run in an non-hierarchical manner, some of the factors that contribute to this are meetings being open to anyone, being held in a relaxed manner over tea and biscuits, in a local community centre. (The Spitalfields Working Party also meets in a local community centre). Although these factors may seem insignificant, they contribute greatly to participants feeling welcome at the meetings, and continuing to attend. The importance of having the meeting open and structured in an un-hierarchical manner, lies in allowing everyone to participate fully, and to have some say in the direction of the organisation. This is not withstanding some of the barriers to participation mentioned in chapter 5.

Pluralism

The fourth criteria of the interpretation of urban social movements is the need for 'pluralism' of group members. All three groups do in fact have a membership drawn from a variety of areas. But all three groups also have certain weaknesses in their membership. The Globe Town Health Action Area has a bias in membership from the local authority, and this as is already mentioned, is its biggest weakness. Although there are a couple of tenants and community groups on the steering committee, the group is not as diverse as the other two. Increasing the variety of organisations represented on the steering committee is an issue being addressed by this group at the present time.

The Spitalfields Working Party has a high tenant representation and good community group representation. Its main weakness is that it has erratic attendance from the local authority and few health authority representatives. However due to the nature of the area that they cover, and the fact that the area is quite small, the membership is quite representative and diverse.

The Health Strategy Group has the most diverse membership of all three groups, and also has the largest number of active participators. At the last Annual General Meeting of the group there were almost 50 people who attended. The weakness in the membership of this group lies in the small number of local authority tenants.

From this preliminary evaluation we can see that the Health Strategy Group and to some extent the Spitalfields Working Party could under the interpretations given in chapter 3, be considered urban social movements, but that under this interpretation, the Globe Town Health Action Area does not fulfil the requirements of the four elements of this interpretation .

In this section we have looked at the groups in relation to the interpretation of urban social movements given in this thesis. As mentioned earlier in the thesis, several writers on urban social movements have laid down criteria which they feel constitute the essential elements of an urban social movement. Before going on to look at the 'New Public Health' and 'Health For All' in the context of urban social movements, an analysis of the three groups and how well they fit other interpretations of what an urban social movements is, will be undertaken.

## 3. The Groups in the context of other theories on urban social movements

By the time that Castells has completed *The City and the Grassroots* (1983) he had developed a definition of urban social movements that had three main criteria[1]. Under these conditions, all three groups meet criteria one, as public health is an issue of collective consumption. All three groups also achieve the second criteria, as all operate in

[1] See chapter 3, page 55 for Castells' three main criteria

geographically defined locations in which they organise their activities. The 'defense of cultural identity' that Castells writes of is difficult to define because he is not explicit about his interpretation of culture, but all three groups place importance on the various cultures that exist in the areas that they operate. However, there is no one prevailing culture that is dominant, either in terms of ethnicity, class, or ideology, although it could be said that in particular the Health Strategy Group encourages defense of the right to one's own culture. Criteria three (reacting against centralised forms of state power, and remaining untainted by association with political parties) taken in its loosest sense could also be said to be a criteria that all three groups attain. However, the Globe Town Health Action Area is partly controlled by the local authority, and although the officers of the local authority do not constitute a political party, some of the decisions that are made or enforced are done so on the basis of the councillors' political ideology. However, Castells' definition is too broad as a definition of what constitutes an urban social movement, since many voluntary associations could actually fit these criteria, and what all writers on urban social movements agree on is that urban social movements contain something more than normal voluntary group associations.

When writing about urban social movements, Pickvance (1985) spoke of certain conditions or criteria that had to be in existence to cause the formation of urban social movements. Pickvance concentrates on the prerequisites for urban social movements to come about, because he was writing from the resource mobilisation approach. There are four pre-requisites; however, the first can be ignored for the purpose of this work, as it relates specifically to issues of housing. [2] In analysing the three study groups in relation to Pickvance we must return to chapter five and the statement of why the groups came about. In the case of two of the groups, they formed due to health reports written describing the situation and its problems, and the third group was formed as a result of a policy decision of the local authority. So all three did form as a result of the inadequacies

[2] See chapter 3 page 57 for Pickvance's pre-requisites

of state involvement in the provision of public health services. The third does not really apply, as the three study groups are not primarily protesting against issues but are searching for solutions to the problems. Criteria four is important to the study groups, as it is issues surrounding the economic and social situation that affect issues of consumption and provision. The areas that all three groups work in are severely economically and socially deprived, and it is this deprivation that is one of the main reasons why the groups were formed to try and alleviate some of the pressures on health caused by deprivation. Pickvance's definition of what constitutes an urban social movement does not really allow for a movement that is trying to promote better health. Pickvance's criteria are more related to the provision of resources, and although provision of resources is an important element in improving public health, the public health movements are also trying to change attitudes and perception about what health is, and how to promote better health. It is this health promotion aspect of the movement that is not really catered for under Pickvance's (or any of the writers discussed here) criteria.

Dunleavy (1980) lists six characteristics that he feels are essential elements of urban social movements.[3] Dunleavy's description of the characteristics of urban social movements are far more detailed then those of Pickvance and Castells, and are also closely related to the interpretation of urban social movements given in this thesis. All three groups exhibit to some degree all of Dunleavy's characteristics, but as in the interpretation given, the Health Strategy Group fits the criteria much more closely then the Spitalfields Working Party or the Globe Town Health Action Area. All have a bottom up pattern of local organisation, grassroots activism and representation of powerless groups. However, Globe Town does not have distance from political activity or an undeveloped hierarchy, and the Spitalfields Working Party and the Globe Town Health Action Area do not have adequate mobilisation techniques, hence the Health Strategy Group fits most closely to Dunleavy's characteristics.

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[3] See chapter 3, page 57 for Dunleavy's six essential elements of urban social movements

Lowe (1986) states four constituents of urban social movements[4]. As with Dunleavy, Lowe's criteria are more specific, and help us to distinguish the differences between ordinary voluntary associations and urban social movements. Again if Lowe's criteria are applied loosely, then all three groups could fit his definition. However, as with Dunleavy's criteria and the interpretation given in this chapter, the evidence from the data gathered in the form of interviews, participant observation and written material, suggests that the Health Strategy Group is the only group that can really be considered to be an urban social movement.

The Health Strategy Group has a wide base from which its membership is drawn, and is also more successful at mobilising new participants to join, and existing participants to involve themselves more fully in the running of the group and its activities. The Health Strategy Group has also taken a much more comprehensive approach to tackling its objectives by employing a number of staff on various projects, and expanding all the time. Although at first the rapid expansion led to problems with managing staff and working in areas where grants were forthcoming rather than towards specific targetted objectives, the growth has led to the group being in a position to determine what areas it wants to work in, and in what areas it will expand. For example the most recent development of projects came after a meeting in which the objectives for the next year were outlined; money was then found for the projects, and the recruitment procedure was carried out by hiring a consultant to ensure that the proper structures were in place. Because the Health Strategy Group is able to be in a position where it can set up projects to operate in this way and because of the innovative work that is carried out, this has led to the Health Strategy Group gaining support and recognition from the statutory agencies, not merely as a community group, but as an *organisation* that the statutory agencies *need* to liaise with.

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[4] See chapter 3 page 58 for Lowe's four constituents of urban social movements.

From the definitions advanced by some writers on urban social movements, any of the three groups could potentially be considered as a local expression of an urban social movement, as the definitions are broad and thus open to interpretation. However, the analysis has shown that the Health Strategy Group is the only group that adequately meets the criteria to be an urban social movement in its own right (as opposed to just being a local expression of a larger movement) in the context of public health and in the particular context of the new public health. In the final section of this chapter the focus of attention will be on how Health for All 2000, and the Healthy Cities initiative, as part of the new public health can be considered as a national and international urban social movements.

## 4. The New Public Health - An Urban Social Movement?

This section is concerned with highlighting how the new public health movement in the context of the Healthy Cities and Health For All 2000 can be seen as an urban social movement, on an international scale. Most writers on urban social movements have studied movements that are organised on a national scale with sub groups in various localities; many writers have also carried out cross-cultural comparisons of urban social movements (Castells 1983, Lowe 1986). However, no one has identified a movement that spans international boundaries in the same way the new public health movement has, and that can in fact be considered to be a global movement. The new public health is a product of modern industrialised society in that it arose in countries which saw the medicalisation of public health during the middle part of this century. In developing countries there is no need for a renaissance in public health since, public health as a discipline, has remained within the framework of the old public health (Gish 1984). However, there has been a shift in the emphasis of some of the key themes of HFA such as community participation and multi-sectoral action (Baum 1990). But both developing and developed countries are

part of the international public health movement led by local communities and organised by WHO (Ashton & Seymour 1988).

The difficulties for considering Healthy Cities as an international urban social movement arise with the fact that Healthy Cities is an initiative started by the World Health Organisation, and as such Healthy Cities has a central body in charge of some of the decision making (Ashton & Seymour 1988). Healthy Cities is organised by a formal structure which could be considered a centralised form of power, thus taking away the power from the base of the organisation, which is where urban social movements are supposed to have their strength. However, it is the WHO's aim to facilitate projects at the local level, which are controlled by the participants and local community, yet feed into the broader WHO structure, as Kickbusch points out:

> "HFA stated that WHO is not an aid organisation, but an organisation that advises on structural change within the health care system and on structural change in relation to planning for health" (Kickbusch 1989, p 50).

The purpose of WHO is to help various communities take on the ideals and objectives of Healthy Cities at the local level, and to provide information on how to meet those objectives effectively, and information on work being carried out elsewhere. There are certain criteria that have been laid down by the WHO in order for a city to become an official "Healthy City' (Ashton & Seymour 1988). However, in general WHO does not dictate how work should be approached or carried out, and therefore WHO does not behave like a government or similar forms of centralised power as it has no power to sanction Cities who carry out work in different ways to the way they that they recommend. In addition there are a number of cities that have borrowed the Healthy Cities ideology without actually subscribing to the official network, or being designated formal healthy cities by WHO (Tsouros 1990).

Advocates of the new public health stress the importance of linking health to social control, or changing the social system of health care (Baum 1990). Changing the social base of society is one of the main points advocated by most writers on urban social movements, as the distinguishing factor between a normal voluntary association and an urban social movement. Although Healthy Cities was initiated centrally from WHO, Healthy Cities does advocate that systems should be set in place to promote social change (Tsouros 1990). Three of the six main aims of Health For All and thus Healthy Cities as outlined in chapter 2 are very close to some of the prerequisites laid down by writers on urban social movements; two of the other remaining three themes are directly related to health - health promotion, and primary health care approach, and the final theme advocates international cooperation.

The first theme addressed by Healthy For All is equity - or reducing inequalities. In order to address this theme groups working towards Healthy Cities must try to be as inclusive as possible, in other words try to encourage participation from all areas of the community, and to improve access by breaking down barriers to participation. Groups must address inequalities in the health, economic, and social systems in order to achieve equity. It is this theme of Health For All which is also the basis for the mobilisation of urban social movements, and thus demonstrates how Healthy Cities has the same objective as other urban social movements mobilising around issues other than health. Because health touches so many aspects of peoples' lives, an urban social movement organised around issues of health actually crosses boundaries with many other urban social movements in areas such as education, trade unions, housing, and welfare.

The second theme of Health For All is 'community participation'. As we have seen in the analysis of urban social movements, nearly all writers talk about the need for participation by the community. The strength of the organisation lies in its base, and the base consists of the community. Healthy Cities, is considered to have a 'bottom-up' structure (Ashton et al 1986), and this is the same structure that is also present in urban

social movements. Even though Healthy Cities is an international movement, with WHO over-seeing its development, it is still able to be a grassroots movement, because the flow of ideas and activity is from the bottom to the top. WHO does not dictate or make decisions that filter down; they may pass information from one division of the organisation to the other, but they do not determine the activities. Again, this organisation reflects the organisation described in urban social movements (See Dunleavy 1980, Castells 1983, Pickvance 1976, Lowe 1986).

The third guiding theme of HFA 2000 which directly relates to urban social movement theory, is the theme of multi-sectoral cooperation. Multi-sectoral cooperation refers to representatives from different agencies working together. The most obvious examples in the context of health are the health and local authorities working together. However there are many other representatives who can work together, such as academics, trade unions, community and voluntary staff, local business, and national government. The Health Strategy Group as an urban social movement is a good example of a group that works in a multi-sectoral way; as we have seen in chapter 5 the group has participation from various different agencies. Multi-sectoral cooperation allows groups to be able to channel their activities into a number of different avenues and it also helps them gain support and work within different frameworks. Writers on urban social movements (Lowe 1986, Dunleavy 1980) also advocate multi-sectoral cooperation as a method by which to achieve the aim of the movement. Urban social movements need to work in a multi-sectoral way in order to achieve their objectives, because good relationships with the 'gatekeepers' to resources within the statutory authorities and funding agencies helps them to achieve their objectives, through processes of negotiation and mediation. In addition as we have seen from the example of the Health Strategy Group, the statutory authorities also gain from the relationship, as the movement is often able to take on activities that complement the work programme of other agencies, and thus help the authorities to achieve statutory obligations

These three guiding themes of Healthy Cities, could have been set down as a definition of the constituents of an urban social movement. They are guiding principles that all urban social movements seem to adhere to because they are the principles that operate in an opposite fashion to the way that the government is perceived to operate. They help to prevent bureaucracy, increase equity, and divert power to the base of society.

It is not only the themes of Healthy Cities that relate specifically to urban social movements; material that has been written on the new public health also falls within the framework of theory of urban social movements. For example Laing and Taylor point out that "the new public health is about enabling people to exercise free choice as constructively as possible rather than coercing them" (Laing and Taylor 1989). What they are describing here is one of the central themes of urban social movements discussed earlier involving the need for people to voluntarily participate or get involved. Laing and Taylor describe a process that involves the whole population becoming involved in the new public health by the virtue of the fact that they will be given more options and choice about their own health on which to base their decisions. Nancy Milio outlines this point further:

> "the promotion and preservation of peoples' health requires more than humane and accessible services. It calls for informed individuals who have the skills to act healthfully within the limits of their personal circumstances, to engage with others in mutually supportive group activities, to support in word and action the creation of healthy environments and of public policies that will foster all of this. These are aspects of the 'new public health'" (Milio 1990, p291)

Milio could have summed up by saying 'these are aspects of a new urban social movement', as the passage deals with the themes of equity, participation, power at the base, support networks, and public policy, all of which have been mentioned by writers on urban social movements.

Turshen in her book *The Politics of Public Health* (1989), when writing about an agenda for action for public health, addresses this need to change the social base of society, and like writers on urban social movements acknowledges that there may be conflicting interests:

> "The need for structural reform, if embraced by public health workers will generate conflicts between public health and private industry because structural reforms change the nature of economic activity and transform social relations. The successful implementation of this public health agenda for the year 2000 depends upon the mass mobilisation of people and their empowerment"
> (Turshen 1989, p 267).

Turshen clearly sees the new public health, and Health For All in the same terms as writers on urban social movements perceive the goals and actions of the movement they are studying.

In summary, the new public health is an international urban social movement, which is organised in different ways in different regions of the world. All members of the WHO are signatories to the Health For All initiative and this initiative has taken on a different organisation in the different WHO regions. However its focus complements the principles of the new public health. Within countries the new public health is organised nationally through the Health For All activities and Healthy Cities Networks (Healthy Cities also operates at the regional level within Europe). Within countries there are expressions of the Health For All and Healthy Cities initiatives in particular cities and localities, and within cities at the community level there are local groups such as the Health Strategy Group which are the grassroots mobilisation of the global new public health movement. Figure 5 summarises this in diagramatic form.

**Figure 5 An Example of the Operational Levels of the New Public Health Movement**

| LEVEL | MOVEMENT EXPRESSION |
|---|---|
| GLOBAL | WORLD HEALTH ORGANISATION |
| REGIONAL/INTERNATIONAL | HEALTH FOR ALL |
| NATIONAL | HEALTHY CITIES |
| CITY | HEALTH STRATEGY GROUP |
| COMMUNITY | |

This chapter has shown through the analysis of the public health groups in Tower Hamlets how each of the groups can be considered as expressions of an urban social movement in public health, according to the broad definitions laid down by Castells, Dunleavy and Lowe of what constitutes an urban social movement. However it is the Health Strategy Group that truly on its own can be considered an urban social movement, meeting all the criteria adequately. The Health Strategy Group meets the pre-requisites of what constitutes an urban social movement that have been advanced by most writers on this subject, and also the definition advanced by this author, that an urban social movement is a voluntary association of people who have come together to work towards a common aim. The group will have a strong attachment to the place where it is working, which will help to highlight the issues and unite the group, and provide the focus of attention.

The Health Strategy Group can also be considered as part of a national and international network forming an global urban social movement, as part of the Healthy Cities and new public health movements. The Health Strategy Group is one geographic level of the movement. The new public health and the Healthy Cities movement meet the criteria described by writers such as Castells, Pickvance, Dunleavy and Lowe on urban social movements, in that they are mobilised at the base of the structure; concerned with a particular issue; promote equity and equality; but above all want to change the social base of society.

The main conclusion to be drawn from this chapter is that the new public health is an urban social movement, operating at a number of geographic levels, and that although it fits within many of the definitions and interpretation of what constitutes an urban social movement, it has features that cannot be explained by traditional analysis of urban social movements. The fact that the new public health is a movement operating at a international and global scale, but at the same time is organised locally within communities, makes it a movement of a type not previously described in urban social movement research. The concept of place, and how it is perceived or sensed, is also of crucial importance to the

mobilisation of people around public health issues, as public health is intrinsically related to the physical, social and economic environment. However, within the traditional literature on urban social movements, the literature on place has been underplayed. Place receives no special attention, and its importance is devalued. The very fact that social movements have been described in the 'urban' situation calls for an analysis of place. This is even more of an imperative with regards to the public health urban social movement, because not only is this movement happening in the city, its main focus is on the environment, and how the physical, social and economic environment affects health, and how it can be changed to promote better health. Therefore in order to understand a social movement working around public health, an analysis of place must be undertaken, in order to see how place helps to focus the groups' attention; directs the work to specific areas; and gives meaning to the overall objective. These issues are further developed and analysed in the next chapter.

# CHAPTER 7

## PUBLIC HEALTH AND SENSE OF PLACE

This chapter analyses how the members of the public health groups in Tower Hamlets perceive Tower Hamlets as a place that has particular meanings for them, related to both their personal experience, and the experiences of their activities around public health. The chapter also examines sense of place at an individual and group level in relation to the way that groups carry out work on public health issues in the area. Two main data sources are drawn upon; the interview material, and the projective technique exercises using photographs. The chapter concludes by examining the importance of looking at sense of place as a key aspect to the understanding of how urban social movements are organised, and of how perception of the environment is an integral element of the new public health.

### 1. "First Impressions"

> "It is only shallow people who do not judge by first appearances".
>
> [Oscar Wilde. The Picture Of Dorian Gray, Chapter 1]

The first question in the exercise schedule[1] was designed mainly to ensure that the respondents were given time to look through their sample, and to inspect the photographs they had been given in their sample. Originally it had not been envisaged that this first exercise would produce relevant material. However, even from this exercise there were some interesting observations that came from respondent's first reactions to each photograph in their set.

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1 A full list of the questions can be found in appendix B.

After all the interviews had been completed and the location of the photographs were revealed to me, I found that in fact there was only one photograph that had not been taken within Tower Hamlets borough boundaries. This was colour photograph 5[2]: the photograph that had been taken opportunistically (Figure 6). A number of respondents, when looking through their sample for the first time, were very quick to point out which photographs they felt had been taken in Tower Hamlets, and which they felt had not. The ones which were selected as being in Tower Hamlets tended to be those of blocks of flats, or of poor quality environments. Those photographs with good quality housing, tended to be perceived as being outside the borough. For example colour photograph 52 (Figure 6) was felt by three respondents not to be in Tower Hamlets:

> **R:** *"A cottage style estate, I'd be surprised if this one was even in Tower Hamlets. It looks to me like it's new".*

> **O:** *"These can't be Tower Hamlets council houses, they are more like council houses you see in the country".*

Both these respondents were residents of Tower Hamlets, and the actual location of this photograph is the Isle of Dogs. However, the photograph did not resemble any housing that they associated with the area. The same quick judgement was made by other respondents about photographs which they felt they could place in a named location outside Tower Hamlets (Figure 7):

> **S:** *"Photo 34b isn't Tower Hamlets, but I do know where it is, it's in Glasgow".*

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[2] The black and white photographs can be distinguished from the colour, because they have the letter 'b' after their number.

Figure 6 - Photographs 5 (Roding Road, Hackney) and 52 (Tiller Road, Isle of Dogs)

Figure 7 - Photographs 34b (British Street, Poplar) and 10b (Coburn Street, Bow)

This respondent had close ties with Scotland, where they evidently have a particular sense of place associated with the type of housing to be found in Glasgow, which does not correspond with that of Tower Hamlets. Another quick judgement made on first seeing a photograph was made by G, who is also a resident of Tower Hamlets (Figure 7):

**G:***"That's (Photo 10b) Canonbury Square in Islington"*

When respondents gave a photograph a named location outside Tower Hamlets they rarely went back on their decision. However, if they made a statement as to where in Tower Hamlets they thought a it might be, or that it was not in Tower Hamlets but they didn't know where it was, they often qualified their statements, or allowed a margin for error (Figure 8):

**J:** *"Photo 23 isn't Tower Hamlets, at least I don't think so,*
*it could be, I might be wrong".*
(Respondent J is a long standing resident of Tower Hamlets).

If the photograph did not match their sense of place of Tower Hamlets, they tried to match it with other places they had as mental maps, and if they were unsuccessful in matching the photograph to an image in their minds, they became unsure of their decision. Tuan (1977, p71-72) in his account of Warner Brown's experimental maze work notes that as people learn about the landmarks around them in an unfamiliar space, encountering a familiar landmark can become an emotional and satisfying experience. Thus when the respondents in the exercise were able to place a photograph in another named place, it satisfied them, and gave them a sense of achievement. Similarly, those people who felt that the photographs were not Tower Hamlets but were not sure where they were, admitted to possibly being mistaken. This was because this is part of the learning process involved in coming to know an unfamiliar space as a place that has meaning for them. When talking

Figure 8 - Photograph 23 (Pennington Street, Wapping)

about how subjects familiarise themselves with a maze, so that it becomes a known space, Tuan states:

> "With further trials he [sic] learns to identify more landmarks
>
> .....They represent for him stages of a journey. Even past errors can serve this purpose. And the subject may say "I made the same mistake last time" indicating he has recognised a locality"
>
> (Tuan 1977, p. 71).

In addition to commenting upon photographs that were considered to be outside of Tower Hamlets, respondents were also quick to point out those photographs that they felt were very true to their conception of Tower Hamlets as a place. One respondent on seeing photograph 25b (Figure 9) said *"definitely Tower Hamlets"*. The same comment was also given by another respondent on seeing photograph 17, and photograph 28 elicited the response *"typical Tower Hamlets"* from two of the interviewees. What was surprising was how quick some respondents had been to identify certain photographs as being Tower Hamlets. This applied particularly to those photographs that could be interpreted as having poor aesthetic appeal and a negative environmental quality. This suggests that images of poor environmental quality are those which are most imprinted within peoples mental maps of Tower Hamlets, and it is these landmarks that are used as reference points within the area.

## 2. 'The Colour Supplement' and the 'Colour Blind'.

Respondents were asked whether they had noticed any differences between the black and white and colour photographs. This was an important question, as in recent years black and white photographs have become less common, and sometimes have an image that is associated with a particular art style, depicting decaying urban environments. Similarly

Figure 9 - Photographs 25b (Berner Street, Wapping), 17 (Solebay Street, Stepney) and 28 (Delta Street, Bethnal Green).


Bar

some people may have found that colour photographs have a more aesthetic appeal to them.

Most of the respondents said that they felt that the colour photographs were more graphic, and emphasized the content of the photographs more than the black and white. This can be illustrated by photographs 25 and 19b, two pictures of a park in Stepney neighbourhood, taken about 100 yards apart. Many of the respondents commented on the colour photograph in terms of its aesthetic appeal, and the detail of the photograph, but the same comments were not made about the black and white photograph (Figure 10):

**G:***"19b is the same photo as 25, a park somewhere, only 19b isn't a very good photograph"*

The content of both photographs is almost exactly the same, it is interesting to note that the respondents felt that the colour photograph made a positive difference. It is possible that the respondent (G) felt the black and white photograph was inferior because the composition of the photograph meant that there was nothing in the foreground. This was supported later in the interview, when the same respondent said:

**G:***"the black and white photos aren't as good, were they taken by the same person?"*

Another interesting point made by many of the respondents was that "you notice the greenery in the colour photographs". One respondent when asked about the differences between black and white and colour photographs said:

**L:***"The colour photos show the green, when you see something green in Tower Hamlets, you take a double take, it makes you question whether it is Tower Hamlets"*

Figure 10 - Photographs 25 and 19b (both are in Harford Street, Stepney).

The same respondent, who is not a resident of Tower Hamlets, and had only started working in the area recently at the time of the interview, also said when referring to Photograph 25 (Figure 10).

**L:***"it looks like Tower Hamlets, but somehow the trees seem bigger, trees in Tower Hamlets don't seem that big"*

The importance that these comments have for the perceived environmental quality of the area lies in the lack of association of green with Tower Hamlets' inner city environment. However other authors (Relph 1976; Lynch 1960; Downs and Stea 1977) have noted that green areas such as parks and gardens are often recounted in peoples mental maps of cities, and are often given a disproportionately large space. However, in Tower Hamlets for those engaged in public health work this is not the case, and ties in with the theory of their perception of poor environmental quality. It is interesting to note that respondent L was not alone in mentioning the effect of 'greenery' in the photographs, and then attempting to relate this to their own images of Tower Hamlets. This may also have been due to the evocative symbolism of trees in literature and art (Cosgrove and Daniels 1988), and how they are often associated with wisdom, light, growth, life, and religion; characteristics that might not be part of the individuals perception of Tower Hamlets, particularly in relation to public health.

Another common response was that many of the black and white photographs looked like period photographs. Photographs 12b and 36b (Figure 11) were used by more than one respondent to illustrate this. Five of the respondents were also under the impression that the black and white photographs had been taken in the past, with the past ranging from two to twenty years. The explanation for the black and white photographs being perceived as older could be because until the mid 1970s black and white photographs were far more common than colour. As one respondent said *"I am not used to seeing black and white photographs any more"*. There were no comments made about the age of the colour

Figure 11 - Photographs 12b (Coldharbour, Isle of Dogs) and 36b (Mile End Place, Globe Town)

photographs. In addition to the black and white photographs being perceived as being old or period photographs, the black and white photographs were also considered to be 'arty', and as we have seen earlier, they were also thought to be inferior by respondent 'G'.

**B:** *"in many ways the black and white photographs look much more arty, they leave more to the imagination".*

Photograph 30b (Figure 12) is an example of one of the photographs that was used to give an example of how 'arty' some of the black and white photographs appeared to be to the respondents. I have framed the word 'arty' in quotation marks, because it was this word that was used by the respondents who mentioned art in the context of the photographs. The definition of this colloquial term in the Chambers Twentieth Century Dictionary is "aspiring to be artistic". I think that the way it was used by the respondents to the question, gave the term certain connotations that I am unable to deconstruct adequately for explanation. However I feel that the term 'arty' when compared to the word art has similar connotations as the word 'lefty' in politics has, when compared to the words 'left wing'. Thus if respondents were interpreting certain photographs as being 'arty' for them, the photographs were more abstract than they were for the other respondents. This was in terms of them not being solely seen in the context of an image of Tower Hamlets, captured by a camera at a specific time, but as a symbol of something other than the place of Tower Hamlets. Tuan points out that symbols can act as a visible sign to enhance a people's sense of identity, and encourage loyalty to a place (Tuan 1977, p159-162). However, although this may be true of nationalistic symbols such as statues, significant buildings, palaces, or art galleries, it is not the same for a symbol that is representing art itself, as the comments on photo 30b seem to imply.

There were also four respondents who said that they felt that there were no differences between the black and white photographs and the colour photographs. Interestingly, despite having stated that there was no difference, two of these respondents when talking

about photographs later on in the session used the phrase *"despite the fact it is a black and white photo, I can still see...."*. This leads to the conclusion that these two respondents also felt that the colour photographs were more graphic and clear in their portrayal of the content of the image, whether that content was perceived as good or bad:

**M:***"the colour ones are better, because you can see the rubbish, in the black and white ones it could be anything, it [being black and white] hides it"*

The impression given by this respondent was that she felt that the black and white photographs were not accurate representations because the rubbish did not stand out. Her implication was therefore that it is better to see the rubbish and decay, than to have it hidden. As a resident one might have expected her to prefer the photographs that improved the image of her home area, however, but as a public health worker, she had a vested interest in maintaining the poorer image of the area in order to demonstrate the need for her services.

Those respondents who expressed a preference for colour photographs as being more graphic, tended to use them throughout the rest of the exercise. Similarly, those respondents who expressed that black and white photographs were 'arty', used black and white photographs for the exercises on choosing appealing and unappealing photographs, but tended not to use them in exercises where they were relating photographs to work, or to Tower Hamlets. This lends support for the theory that photographs seen as 'arty' are thus disassociated with a real place, and become objet d' art.

For the exercises where respondents selected their own photographs from their sample, black and white photographs were selected by 33 percent compared to 67 percent for colour. Of the photographs used, 40 % were black and white, and 60 % colour. This variation allowed the respondents, to use both black and white and colour photographs in roughly the same proportions that they were given. However there was one exception:

Figure 12 - Photograph 30b (Tower Hamlets Cemetery, Poplar)

when respondents were asked to select photographs that appealed to them, only 19% of the total photographs selected were black and white. This supports preference for colour among the respondents as a group.

## 3. Poles Apart - Deconstructing Place Constructions

Each respondent was asked to produced two constructs[3],[4] and each except two had different constructs. These two who chose the same photographs for the two poles of their constructs had different middle photographs. There were also some photographs which were chosen more often then others the reason for this was due to the extremes that some of the photographs represented. The most common construct used was that of developed, attractive environment against undeveloped or run down unattractive environment. An example of this construct can be demonstrated using photographs 7 and 33b; these are the two photographs that were used by two respondents as poles for their constructs. This was explained by the first respondent as (Figure 13):

> **V:***"7 appears to be a Victorian Terrace, refurbished in excellent condition, quite possibly in Bow, whereas 33b is a very run down, unattractive part of Bethnal Green".*

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[3] See Chapter 4 for an explanation of the full methodology and justification for selection of personal construct theory.

[4] Respondents were asked to select two photographs that were some kind of opposite for them, and then a third photograph that was somewhere in between. They were then asked to explain by what criteria the photographs formed opposites to one another, and this became their construct.

Figure 13 - Photograph 7 (Campbell Road, Poplar) and 33b (Bacon Street, Bethnal Green).


The respondent (a resident) was correct in thinking that photograph 33b was Bethnal Green, but in fact photograph 7 was taken in Poplar, and not Bow. The importance of the contrasts of the neighbourhoods Bow and Bethnal Green used by many people is discussed later on, but it should be noted here, that Bow was perceived to have the most positive or desirable environment in Tower Hamlets and Bethnal Green the most negative, or least desirable environment in the area. In saying that the housing was attractive and using the superlative 'excellent', it seemed most probable that the respondent wanted or thought the housing to be in Bow, to match up to her image of that neighbourhood. The second respondent explained the construct of 33b and 7 simply as *"dereliction versus restoration"*.

Another commonly used theme for a construct was aestheticism. Aestheticism is an important construct in terms of sense of place:

> "People demonstrate their sense of place when they apply their moral and aesthetic discernment to sites and locations" (Tuan 1974, p234)

The constructs of aestheticism can be demonstrated by the poles of photographs 23 and 32 (Figure 14). One respondent (W) described this construct as *"the aesthetic against the grotesque, preservation as against desecration"*. Photograph 23 was also used in another construct of aestheticism with 17b as its pole. The respondent (P) commented that "23 is an outstanding photograph of a beautiful building. The opposite? Well it has to be 17b". Respondent (P) is a resident of Tower Hamlets, and has lived in the area longer than any other respondent interviewed. In the map exercise, he placed photograph 23 in Tower Hamlets. What is most interesting about this, is that even though this man had lived in Tower Hamlets all his life, in the map exercise photograph 23 is the only photograph which he correctly identified, and placed in the right neighbourhood. The respondent said that his difficulty lay in not knowing the neighbourhood boundaries, but during the exercise he placed more than half his sample in the 'out of Tower Hamlets' category. This would

suggest that length of time as a resident or working in Tower Hamlets does not affect accuracy in identification of photographs, and that sense of place is more important.

Photograph 17b (Figure 15) was also used by three respondents as one bi-polar extreme in the construct of good and bad housing, this photograph was perceived by most of the respondents to be a particularly run down, decaying environment. An example of a construct using this criteria can be demonstrated with photographs 27b and 17b. The respondent who chose these photographs qualified the decision by saying:

> **G:***"27b and 17b are an opposite of housing that you live in.....*
> *one communicates choice, in that people have probably bought those,*
> *and the other lack of choice in that you are put there and it is hard to*
> *get out".*

Respondent G commented to me that she had once stayed in a block like 17b at a particularly difficult time in her life. She used the words "I had nowhere to go at the time, and this was the only place I was offered, and I hated it there". This respondent obviously felt a lack of 'choice' when she was in similar housing, and thus her construct was based on this concept of 'choice', which in turn was based on her own personal experience. A number of people used the word 'choice' in their constructions around housing, the presumption being that people living in accommodation that is depicted at the negative pole of the respondent's construct have not chosen to live there. This is a strong value judgement that was made in a number of similar ways by almost half of the respondents, in that as they felt it was a poor environment, they could not conceive that others may have chosen to live there. It may be that the respondents to the question would

Figure 14 - Photograph 23 (Pennington Street, Wapping) and 32 (Copperfield Road, Poplar).

Figure 15 - Photograph 17b (Reardon Path, Wapping) and 27b (Glenn Terrace, Isle of Dogs).

not choose to live in that accommodation. However, this might be because of the options and position that they had. Other people with different home experiences and options might choose to live in such accommodation. Tuan adds to this by stating:

> "Working class and poor people do not live in homes and neighbourhoods of their own design. They move into residences that have been abandoned by the well to do or into new subsidized housing. In both cases the physical structures do not reflect the dwellers ideas".
>
> (Tuan,1977, P171)

Tuan points out that familiarity and sentimentality take much longer to be fostered amongst this group of people compared to those who are able to buy and design their ideal environment. This could imply that sense of place can only be fostered around a positive environment i.e. one that is appreciated. Although this may be true in some cases, it is also possible to have a sense of place that is fostered on negative environment, like the public health workers in Tower Hamlets, and it is also possible for people to find attraction in places that others find unattractive. This can be illustrated by the case of photograph 42 (Figure 16), which appeared at the negative end of a number of respondents constructs. This was selected out from the sample as an unattractive photograph by most of the professional respondents, and was also selected by one respondent as a place that would be nice to live in (T) *"it looks clean, and the building looks nice and bright, I would like to live there"*. The same photograph was described by other respondents as: (G) *"horrendous, to expect people to live like that is just, an inhumane way to house people"* and (A) *"I would hate to live in it, I have never seen anything like it, the architect should have been shot"*. These differing opinions can be linked to peoples differing experience of housing, which is not necessarily linked to class: two of the respondents who describe themselves as 'working class' and who might have been expected to have experienced this type of housing, were amongst those who criticised photograph 42 as a place to live in. Although this is one case where photographs were used differently by two respondents, in general

Figure 16 - Photograph 42 (Warley Street, Globe Town).

there was more congruence between the respondents constructs than incongruence.

Once the poles of the constructs had been identified each respondent was asked to place a photograph between the two poles of each of their two constructs. This exercise caused some difficulty for about one third of the respondents, and for most people the difficulty arose from the photographs not providing them with an obvious choice. The respondents all found it relatively easy to choose two photographs that were opposites or poles, because they could look for the greatest contrast in their selection of photographs, but selecting a middle photograph required more thought and thus took much longer.

An example of a construct by one respondent was using photographs 22, 15, and 45 (Figure 17). The construct was of decaying environment against developing environment, and she selected photograph 15 as the middle photograph because:

> **A:***"15 goes between 45 and 22 because it looks like there is some life there, but it is still a bit bleak looking really, but it is obviously surviving, there are shops and things".*

What is interesting with this construct is that the poles selected represent movement in that they were described as decaying, and developing rather than decayed and developed, and the middle photograph represents a transitional state that could be moving towards either pole. The idea of transition from the negative pole of a construct towards the positive end is important because the aim of the new public health movement is to progress towards better public health, for which the evidence of achievement is the transition from one pole to another, demonstrated in improved environmental quality. Photograph 15 was one of the

Figure 17 - Photographs 22 (Copperfield Road, Stepney), 15 (Chicksand Street, Bethnal Green) and 45 (Lindley Street, Stepney).

most selected middle photographs for people's constructs[5]. This popular selection can be attributed in part to the variety of the content of photograph 15 and because it does convey a sense of transition. Another respondent who selected this photograph said:

**N:***"It is more a sort of inner city structured area, you get tidiness as well as commercial area, and also Tower-Hamlets-like-streets, you have a mixture of services, housing and commercial shops".*

Photograph 8 (Figure 18) was used by more than one respondent as the middle or transitionary photograph representing a construct of housing tenure and wealth of the occupier.

**M:***"It is some council housing in good condition, - new doors -, the paint isn't chipping, - you could say that they are not as affluent as 5 but they are better than 30"* [6].

This comment by the respondent infers how people are rated along with their housing. She used the term 'they' to talk about houses, but she also included the residents of the houses in her construct. Many respondents linked the residents with the focus of the picture when

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[5] Photograph 15 was selected as a middle photograph by five respondents. This photograph appeared in the selection of six out of the seventeen respondent's selections.

[6] It is interesting to note that Photograph 30 was perceived as housing by a number of respondents including this one, when in fact it is a derelict bath house. However it is possible that it is used by homeless people for temporary shelter. The fact that this respondent saw it as housing could also point to how people in Tower Hamlets are more familiar with this type of 'slum' environment, then people who don't live in an inner city environment.

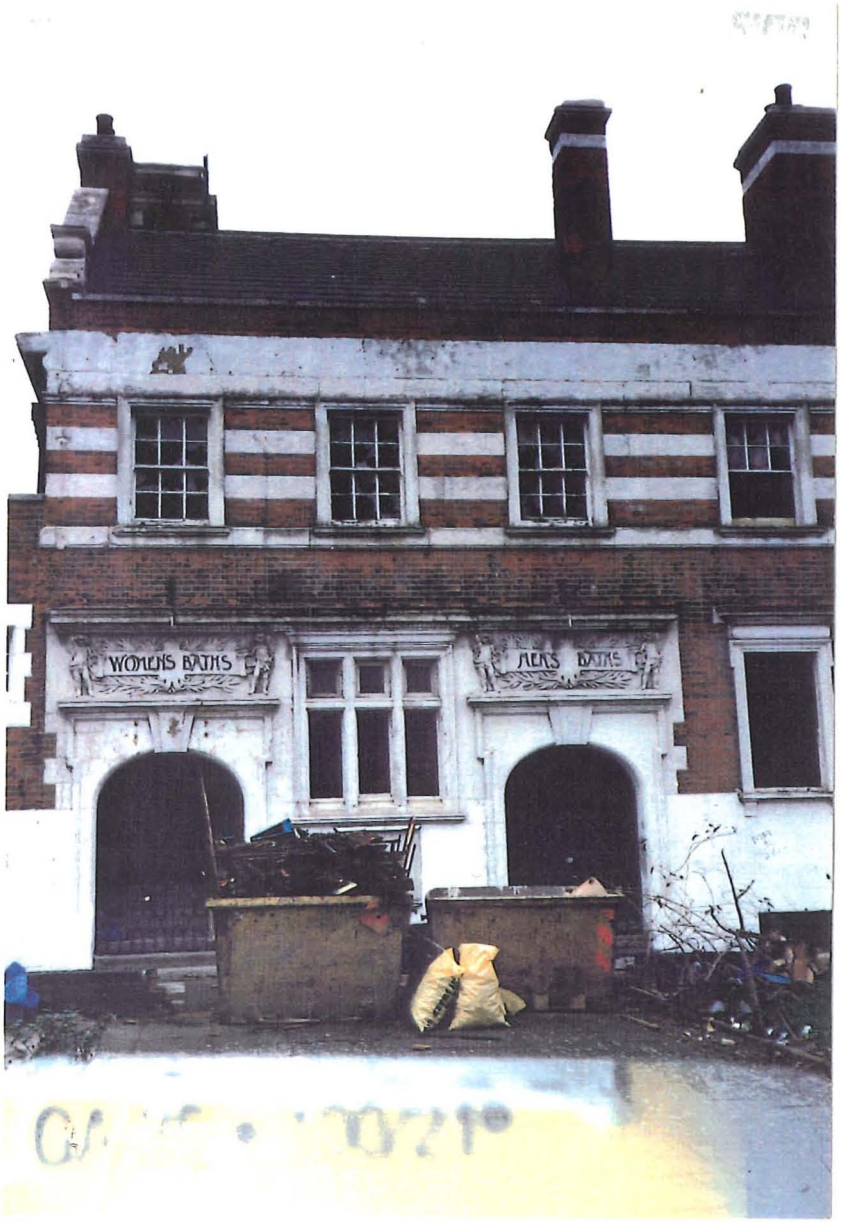
looking at photographs of housing. This is a good example of how personal constructs can work, by linking the impressions, thoughts and knowledge that respondents have about people in Tower Hamlets to the photographs they are looking at, - especially as most photographs did not include people within them.

A similar viewpoint using 8 (Figure 18) as a transitionary photograph from one pole to another (from renting to owner occupancy) was also expressed.

> **R:***"8 has been council owned, but you can see some of the tenants have bought their houses by the change in the doors, that indicates the person has bought their property, it is more attractive than 17b, and shows people have chosen to live there".*

A number of the respondents made the comment that all housing has a purpose and yet can still be decorative and appealing, but that in Tower Hamlets, most of the housing is functional and very little thought appears to have gone into what it is like to live in an unattractive environment. The most frequent constructs developed by the respondents were about housing quality or environment quality - two of the most important aspects of all public health work, and especially important within the new public health framework, which advocates clean, healthy, positive public environments and shelter, as two of the fundamental pre-requisites for a healthy population. The second important point to conclude from this exercise is that the images selected for the lower or negative pole in the respondents' constructs, tended to be images that were associated with Tower Hamlets, and the images at the positive end of the construct were often thought to be from outside the area. This reinforces the concept that those working in public health in Tower Hamlets perceive the area to have a poor quality environment, and to be of a lower quality than other London or other similar inner city environments which they know; environments that in theory they are working towards. This was despite many of the more positively perceived photographs being from within Tower Hamlets.

Figure 18 - Photographs 5 (Roding Road, Hackney) , 8 (Newby Street, Isle of Dogs) and 30 (Dunbridge Street, Bethnal Green)



WOMENS BATHS
MENS BATHS

## 4. A Positive Attraction.....

The respondents were asked to select from their sample the three photographs that appealed to them the most, for whatever reason. There were two motives behind this question. The first was to see whether in the map exercise or at any other time there was a relationship between the type of photographs that the respondents selected, and where they thought the photograph subject was located. Secondly, to see if a pattern emerged of what type of photograph most appealed to the respondents, and whether this could be linked to common perceptions of Tower Hamlets.

The most selected photograph for this question was photograph 25 [7] (Figure 19), which was also a photograph used to demonstrate the differences between black and white photographs and colour. It is interesting to note that of a total of 39 photographs that were used for this question, only 8 were black and white. Most of the colour photographs that were selected also had more greenery within the photographs then the average. Obviously, 'greenery' is an important part of aesthetic quality in the analysis of this selection of photographs, and the comments made by the respondents also indicate that greenery is an important part of perception of a place as a positive environment:

**C:***"25 is my dream for Tower Hamlets, green and tidy"*

**Q:***"I like 25 because it is a piece of parkland or open space, it is a lung for the people who live in this urban environment".*

**P:***"obviously number 25, the park, its a bit of green, it has to be nice"*

---

7 This photograph was in 5 (out of 17) respondents selections and was chosen by all

5.

Figure 19 - Photograph 25 (Harford Street, Stepney).

**O:** *"Anything with a bit of green in it gives you some hope".*

These images relate to the vision of the future that the members of the movements have. As discussed in chapter five, urban social movements have to have a goal that they are working towards; a collective vision for their future. The photographs selected represent this dream in the form of a clean healthy positive environment, which also infers a much better standard of public health.

Photograph 30 (Figure 20) was selected by a number of respondents, for a variety of reasons, but mainly because it reminded them of an image of Tower Hamlets in the past. Some of the reasons given for selecting this photograph were:

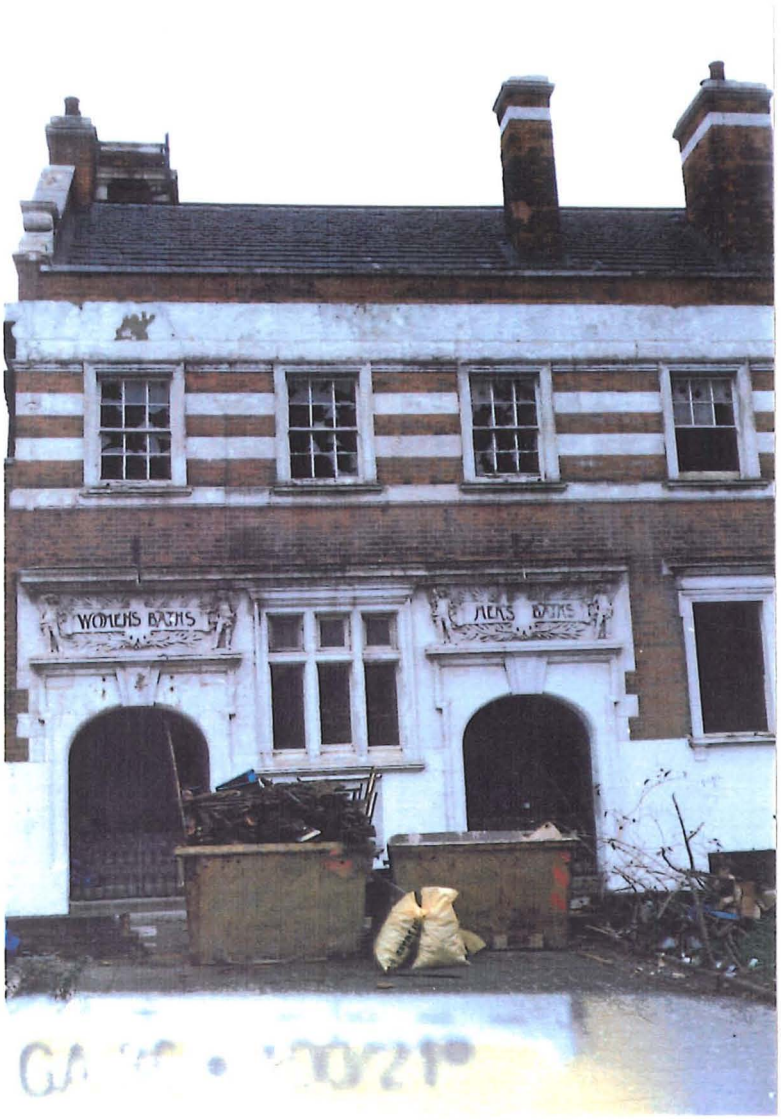
**G:** *"Ramsay Street baths I like that building, the shape of it, - it reminds me of the history of Tower Hamlets, - I hope that they are doing something with it"*

**L:** *"I've chosen this one because it intrigues me, I'd stop and look at this and see if I could get in".*

**P:** *"It's got a lot of character in it, I find this picture nostalgic"*

What is interesting about this photograph is that some of the younger respondents, particularly those who were new to Tower Hamlets felt that this photograph was unsightly. Besides appearing at the negative end of some respondents' constructs, for other respondents it was also selected as an unappealing photograph. As Eyles points out, a nostalgic sense of place does not involve "fantasy or misrepresentation, but it firmly locates the sources of identity in the past". (Eyles 1985, p133.) Thus the respondents who saw the photograph as nostalgic, also saw the fact that the building was now run-down and

Figure 20 - Photograph 30 (Dunbridge Street, Bethnal Green).



unsightly, but that this was subsumed by the predominant sense of place evoked through nostalgia, for what the building had stood for in the past.

Photograph 18 (Figure 21) was also selected as an appealing photograph by a number of respondents, who felt that the way that the photograph had been taken attracted interest to find out more about the content:

**O:***"I like that alley, I want to go down and look around the corner, and find out what it was used for".*

**B:***"18 is something hidden, but very pretty"*

There were a number of photographs that were selected by one respondent only, based on the photograph's aesthetic appeal, or because like photographs 18 and 30, they reminded them of the past, and made them curious about what was in the place depicted but out of view.

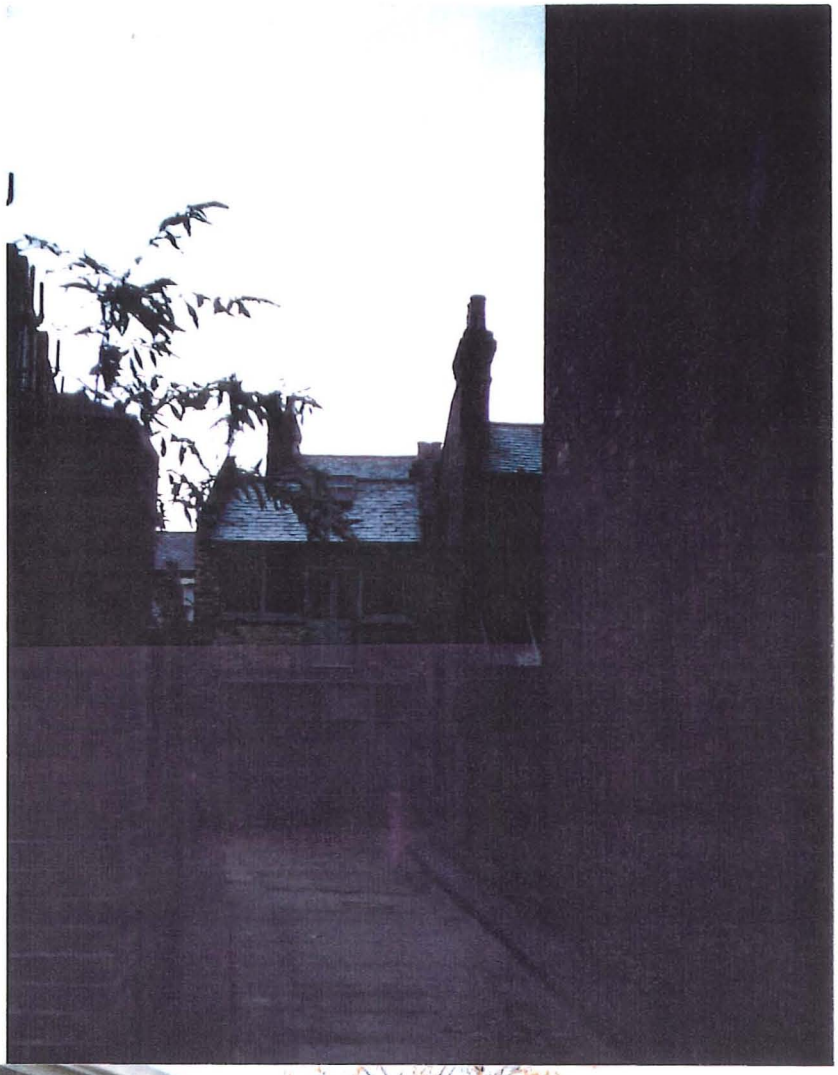
The other criteria that most respondents used when discussing an appealing photograph was an environment in which they would like to live. Photograph 7 (Figure 21) was picked out by four people as their ideal, and similar photographs of residential streets, with houses (not flats) were selected.

**Q:***"7 appeals because it is the sort of place I would love to live in"*

**G:***"everybody's ideal, - a bit of personal space, and a front door".*

The comments made about ideal housing were also re-iterated in the respondents' descriptions of what it would be like to live in certain areas. These tended to reflect the common vision of the future that the public health groups are working towards.

Figure 21 - Photographs 18 (Temple Yard, Bethnal Green) and 7 (Campbell Road, Poplar).



## 5. .....and A Negative Detraction

Respondents were asked to focus their attention on what they found unattractive or unappealing in their sample of photographs. Again, the respondents were each asked to select three photographs.

Photographs 42 and 46 (Figure 22) were the two most selected photographs in this category[8]. We have already seen some of the comments given about photograph 42, but the respondents' views about photograph 46 are very similar and included the following comments:

**C:***"A type of construction that lends itself to vandalism"*

**G:***"Frightening, I would feel stressed about living there"*

**J:***"communicates a complete lack of thought"*

**A:***"a stairwell and walk way, - I would find this intimidating"*

---

[8] Photograph 42 was in 7 out of 17 selections and was chosen by 6 respondents as an example of an unattractive picture; photograph 46 was in 9 respondents' selections and was chosen by 6. This photograph (46) appeared in a high number of selections and therefore may have a higher representation in this section.

Figure 22 - Photographs 42 (Warley Street , Globe Town) and 46 (Tiller Road, Isle of Dogs)

Interestingly, one respondent had placed photograph 46 as the centre photograph of a construct on aestheticism, between photographs 23 and 32, saying that the photograph had an "art deco" feel. [9]

The next most popular criteria for selecting photographs which were unappealing to the respondents was lack of cleanliness or a perception of a poor quality environment. Photographs 22 and 9 (Figure 23) were selected by a number of people who used this criteria:

**G:***"It [photo 22] just looks dirty and threatening".*

**L:***"If I was walking past there at night [photo 9] I'd be thinking 'what am I doing here'".*

**J:***"I don't like number 9, - it is a pile of dumped rubbish, - reminds me of dirt and unhealthy situations and the things that people complain about".*

Although only two photographs selected by the respondents to show this have been displayed, nearly all the respondents used the theme of poor environment with at least one of their unappealing photographs, and a variety of photographs were used. When asked to carry out this exercise four of the respondents questioned the fact that I wanted them to select only three photographs that did not appeal to them, these statements suggest that the 'normal' image of Tower Hamlets is one of poor environment, and that it is unattractive. As none of the respondents qualified their statements or suggested that it was their own unique perception it appeared to be assumed by them that I felt the same way that they did,

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[9] This photograph, and the reactions to it were especially important for me, because it is a previous home of mine. The significance of recognition of the content of photographs and perceptions of them as photographs will be discussed presently

Figure 23 - Photographs 22 (Copperfield Road, Stepney) and 9 (Gowers Walk, Wapping)

and that this perception is the norm. There was no difference in the comments expressed by those who are residents in Tower Hamlets and those who are not, nor was there any difference between those respondents who were public health workers (professional or voluntary). However those respondents who were tenant representatives to the meetings did not express this negative image, whereas those who were both residents and workers did. I believe that this image was not expressed to me because to most of the latter I am considered an outsider (as I was not born and raised in the area). I have heard negative comments about Tower Hamlets image expressed by local tenants, but noticed that it tends to be when they are in a group together. This negative view of Tower Hamlets is a view commonly presented to outsiders (those not from the area) by public health workers in Tower Hamlets. The negative images reflected in the media impression of Tower Hamlets, serve to fuel the unquestioning belief by 'outsiders' that the Borough has a poor environment. As Relph points out this can lead to:

> "Observations are fitted into the ready made identities that have been provided by mass media or into a priori mental schemata, and inconsistencies with these are either ignored or explained away".
>
> (Relph, 1976, p60)

What is unusual among those concerned with public health issues in Tower Hamlets, is that in 'public' outside Tower Hamlets, the public health workers seek to enforce the media impression of a poor environment. By contrast, other groups from within the borough such as the local authority, local business, and local politicians seek to promote Tower Hamlets. This represents two contrasting strategies for canvassing interest in Tower Hamlets. Some groups/individuals are obviously trying to attract new people, investment, and interest in the area by promoting the positive aspects of the borough, whereas the public health workers are trying to do this by presenting a negative image, almost as if they are trying to win the 'sympathy vote' rather than admiration. This also operates as a

successful tactic in trying to secure resources for the borough by demonstrating the high level of needs.

By maintaining an image which is negative, the public health workers have the opportunity to show to outsiders - in terms of their work - what they have been able to achieve, despite having to work in such a poor area. Amongst other community and professional public health workers from outside Tower Hamlets, there is an acceptance of the fact that Tower Hamlets is one of the most deprived areas in the country, and thus the public health workers from Tower Hamlets are given the opportunity to continue with their 'negative' boasting. As Berger and Luckmann point out :

> "Once developed by a group or individual , or the mass, an identity of a place will be maintained so long as it allows acceptable social interaction and has plausibility - that is so long as it can be legitimated within society". (Berger and Luckmann, 1967, p94)

Therefore, as long as the image of Tower Hamlets that is portrayed by the public health workers is validated by other public health workers from outside of the borough, and by the mass media, there is no need for the public health workers to re-evaluate their perceptions, and question their validity, in terms of the their overall perceptions of an area that includes a variety of differing places.

One of the most common themes that ran throughout all members of each group was their perception of Tower Hamlets as being linked to poor environmental quality. This can be summed up by one respondent who said:

> A:*"Given that I am interested in public health, and the people I see my work addressing, and social causes of ill health,.....I think of Tower Hamlets in terms of poverty, of poor housing, of poor*

*quality of environment, of lack of policy shaping service provision, of having missed out on the developments that you see in other parts of London".*

Many people gave the response that they felt that they perceived and identified more with the poor parts of the borough, yet one third of the borough is covered by the London Docklands development where huge housing and work place development is taking place. However most of the housing and jobs that are being created are not for the local residents of Tower Hamlets, and as with most developments they are within the private sector. It is unfortunate that in Tower Hamlets especially, new development highlights the surrounding poverty to a greater extent than it does elsewhere.

The concepts of 'insideness' and 'outsideness' apply very strongly to the Docklands area. [10] As Relph says:

"To be inside a place is to belong to it and to identify with it, and the more profoundly inside you are the stronger is this identity with the place". (Relph 1976, p49)

Amongst the public health workers who were interviewed, the Docklands area is no longer considered part of Tower Hamlets because of the new development that has taken place, it no longer has the identity of the 'old' Tower Hamlets, and this is the view taken by the 'insiders' of Tower Hamlets. However, if someone from outside of the borough makes reference to the development that has taken place in the Docklands then the workers become defensive, and include the Docklands area, and in particular highlight the fact that some parts of Docklands, particularly the Isle of Dogs, have become even more isolated since the

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10 For a detailed discussion of the concepts of insideness and outsideness see Relph 1976, Ch 4, p49 - 55.

development of the area. These differing opinions are concerned with the fact that there is a trend to be negative towards the Tower Hamlets environment, and therefore it is incongruent to the workers to include the newly developed areas. However, if an outsider points to this new development as a positive effect on the environment and the people who live there, it must be pointed out to the outsider that the Docklands development is causing greater inequalities than existed before, as it is against the Tower Hamlets workers' interests to allow outsiders to think that the situation is improving. As Relph points out:

> "It is not just the identity of a place that is important but also the identity that a person or group has with that place in particular, whether they are experiencing it as an insider or an outsider".
>
> (Relph 1976, p45)

It is for these reasons that the public health workers are able to maintain two different perceptions of the Docklands according to whether they are acting as insiders communicating with other insiders from Tower Hamlets or acting as insiders explaining to outsiders who are not from the borough.

In order to operate within a professional public health genre, it appears that there is a consensus of shared group identity or, put another way, a shared sense of Tower Hamlets, which consists of poor quality housing in areas that are also perceived as environmentally poor. The members of the Public Health groups have a sense of Tower Hamlets constructed from the poorer, most deprived areas of the borough, or to be more accurate the deprived areas of the borough that they are most familiar with. While this is certainly a result of the common experience of working around pubic health issues in Tower Hamlets, these images also help create and structure the experiences the workers have. An image has been defined by Boulding (1961) as a mental picture that is the product of experiences, attitudes, memories, and immediate sensations. He says that it is used to "interpret information and guide behaviour as it offers a relatively stable ordering of relationships

between meaningful objects and concepts". Thus the shared image that exists between the workers/members of each of the groups is one of the main motivating factors for the type of work that they undertake. But as Relph (1976) points out, through the work of interest groups, an image can be projected in which the identities of places of significance to that group are a reflection of group interests and biases. In the case of the groups working around public health issues in Tower Hamlets, this is a relevant comment about their work, in that by having a common sense of place and purpose the movement has a common mobilising factor to initiate a response in the form of concerted action and activities.

## 6. Residential 'Properties'

Each of the respondents was asked to think about what it would be like to live in the area that each photograph portrayed, and what the characteristics or properties of the photograph suggested about the accommodation. As Gould and White state "we know that images of residential desirability are highly stable and predictable in the aggregate" (Gould & White, 1974, p 174.). For this reason it was decided that using images of housing would be a good criteria of measurement for sense of place. Photographs 7, 5 and 4b (Figure 24) were the areas that most people thought easy to live in.

**O:***"I'd love to live in that street, it looks a nice place to be [4b]"*

**T:***"Number 5 is perfect I would love to live there"*

**Q:***"I wish I lived in number 7, and had the income to go with it".*

Figure 24 - Photographs 7 (Campbell Road, Poplar) 5 (Roding Road, Hackney) and 4b (Bancroft Road, Globe Town).


It was quite easy for most of the respondents to say what it was like to live in this type of accommodation. Some of the respondents indicated that it was the type of housing they already lived in, and for other respondents it was the type of housing that they were aspiring to live in if they had the money to pay for it. It is interesting to note that a high income was associated with good housing by the majority of respondents, suggesting that if you do not have a good income, you can not expect to have good quality housing. However, the respondents who made reference to income were all professionals, salaried as opposed to waged, and therefore in terms of the average earnings for Tower Hamlets, would be considered to have a high income.

The images in these photographs evolved a strong sense of place in terms of the image of a home as opposed to a dwelling. This was particularly true of those respondents who had lived in this type of accommodation for a long time, or in the past. As Relph (1976) points out, people's attachment to home area, and increased sense of place, increases with length of residence. The next two photographs demonstrate housing that was perceived to be an example of adequate housing, that was not unattractive. A few of the respondents mentioned that they currently lived, or had had experience of living in this type of housing. Photographs 1 and 16 (Figure 25) are good example of this criteria of 'reasonable housing':

**T:***"Photo 1 is reasonable council housing, and a better environment than the blocks behind".*

**J:***"its modern housing with the basic amenities [photo 16]"*

Most of the respondents commented that they felt they would not be able to live in tower block accommodation and felt that it would be unbearable. Many of the women respondents felt that entering and leaving buildings was an important criteria for what it would be like to live in an area, and that in tower blocks, especially those with walkways, this would be extremely unpleasant. Many of the women respondents also said that when

Figure 25 - Photographs 1 (Libra Road/Wrights Road, Bow) and 16 (Ovex Close, Isle of Dogs).

thinking about what it would be like to live in these areas they had to take intoconsideration the fact that they had small children .

Photograph 29 (Figure 26) is an example of the type of housing that most people felt that they would not be able to tolerate, and that it would be difficult to live in. The main reasons given can be summed up by one respondent who said:

**Q:***"Flat dwelling like this is not convenient in terms of space, noise and privacy"*

One respondent felt that this type of estate had a particular type of resident:

**R:***"This is an established part of the East End, - I don't know if I could put up with the racism of my neighbours, if I can use a massive stereotype, but those are the sort of very protectionist estates".*

These quotations reflect some of the stereotypes that exist within the groups. These stereotypes are not always accurate, but represent the prevailing views. Photograph 41 (Figure 26) is also an example of the type of housing/building that most of the respondents felt they would not be able to live in, but this was not due to the construction of the building so much as the state of repair.

**B;***"it just shows neglect, eyesores, lack of planning, everything looks boarded up and dead".*

In other words this environment is decaying, and to live in such an environment would not be conducive to a positive sense of physical or mental health. A building such as this also represents the opposite of what the groups are trying to do in terms of breathing new life into the area.

Figure 26 - Photographs 29 ( Warley Street, Globe Town) and 41 (Club Row, Bethnal Green).

## 7. A Working Environment

Respondents were asked to select any photographs from their sample which they thought had relevance to their work in relation to public health. The overwhelming response to this question was the selection of a photograph that showed a tower block, or particularly old local authority housing. The type of comments made by the interviewees were:

**G:***"The ones that strike me as having more relevance than others are the flats".*

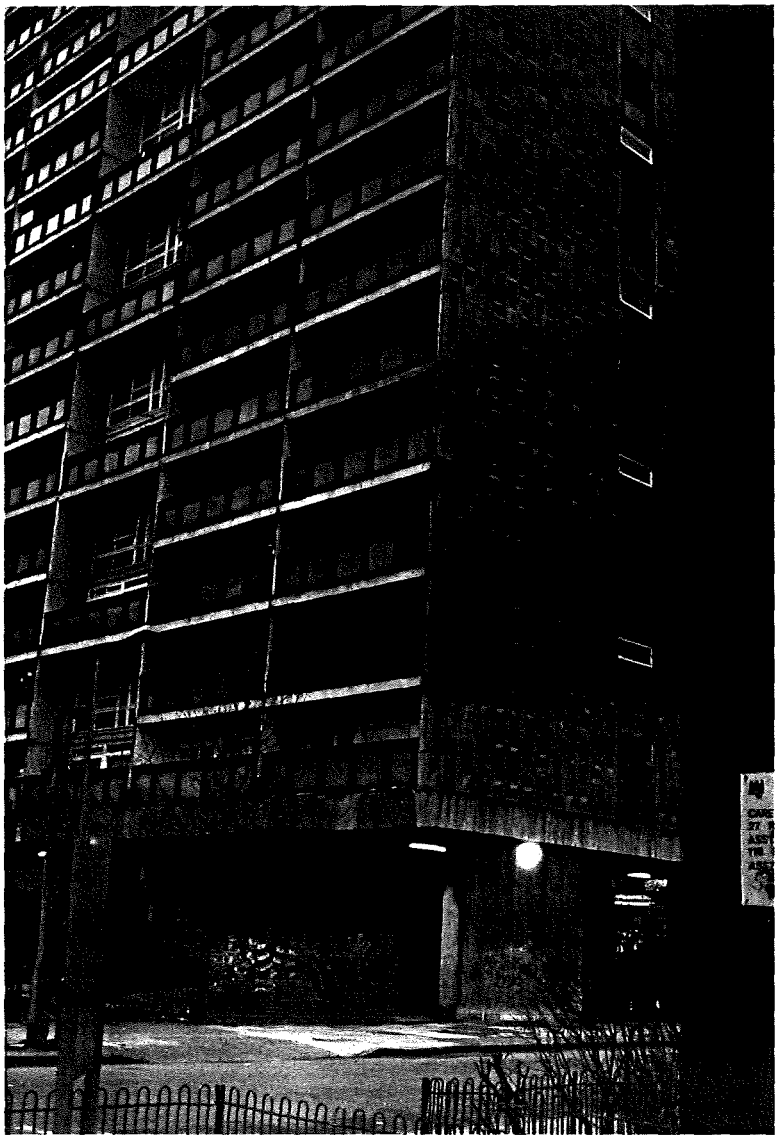
***A:****"yeah, the council block ones.....most people live in council accommodation which looks like one thing or another, so all of those are relevant".*

***Q:****"I have much more to do with local authority housed people....who are living in accommodation that has the classic characteristics of damp, overcrowding, and condensation".*

***B:****"Pictures like this, 15b,* [Figure 27] create *the kind of stress that make people ill, and that is the first thing I think about, the kind of tension that it would create having to live in that environment constantly".*

What is important about the answers to this question, is how more than half the respondents talked specifically about tower block living, or council house living. Only two respondents mentioned that their work might be concerned with people living in privately owned accommodation. However, virtually all the respondents are employed in some capacity to do with public health, which is a subject that affects the whole population, but they had the immediate response that their work was more concerned with local authority, particularly

Figure 27- Photograph 15b (Knapp Road, Poplar)



tower block, residents. There were subtle differences in their approaches to sense of place when asked about living environment, and sense of place when related to work environment. When thinking about the living environment, respondents personalized the question to themselves and their experiences much more than when they were thinking about work environment, where the image of the tower block seems to be a symbol for inner city public health work. In order to see whether these individual perceptions of place can be extended to the group or movement level, and how it is seen in the context of public health work, we need to move to the analysis in the next section. This will consider how the groups perceive the areas in which they are working, and whether as a movement, they have a united sense of place constructed from their experiences of carrying out public health work in the area.

## 8. Neighbourhood Identity

The Health Strategy Group, the largest group studied in terms of the geographical area it covers, shares a common sense of place in terms of how it perceives the borough, yet this concept of the borough excludes almost half of it. To quote one interviewee:

> **A:***"The images of the past are very strong for me, when I think of Tower Hamlets I think of Spitalfields, Whitechapel, and Bethnal Green.....I don't know Bow or Globe Town at all, and the Docklands well...that's not really Tower Hamlets any more, not Canary Wharf".*

This respondent was not a resident of Tower Hamlets, and at the time of being interviewed had not been working in the borough for long. This suggests that much of the knowledge

that her sense of place was fostered upon had come from the media, or from the image presented by Tower Hamlets' residents and workers.

Of all the people interviewed from the Tower Hamlets Health Strategy Group, all but one identified Spitalfields as synonymous with the image of Tower Hamlets, they also included most of the western part of the borough, and the areas along the two main A roads, the A11 and A13 in this perception [See map in Ch 5 on page 110]. The two neighbourhoods most frequently mentioned were Stepney and Bethnal Green, and this may be due to the fact that these two neighbourhoods have taken their names from the old administrative boundaries that were in existence even before Tower Hamlets became a borough. None of the interviewees mentioned the neighbourhoods of Wapping or Bow when talking about what Tower Hamlets was like.

From analysing the minutes of the Health Strategy Group and other documentation, it is apparent that the majority of the group's activities take place in Bethnal Green and Stepney, although recently some work through the Healthy Cities project has been undertaken in Wapping and the Isle of Dogs. Thus the common identity or perception the group has of the borough is channelling the focus of attention in terms of activities around public health into the commonly identified/perceived areas.

The group workers spend all or most of their work time in Stepney or Bethnal Green. The group's office is in Bethnal Green, and thus their links with the area are again reinforced, as their knowledge and experience of these places is greater. A high proportion of members of the executive committee (50%) spend all or part of their work time in these two neighbourhoods. There is no local authority representative from the neighbourhoods of Bow, Poplar or Globe Town on the steering group, and only one each from the neighbourhoods of Wapping and the Isle of Dogs. It is interesting to note that only since there have been representatives from Wapping and the Isle of Dogs, these two neighbourhoods have begun to feature in the minutes.

Although the Health Strategy Group was set up to serve the whole borough, it is apparent that many areas are omitted. When this observation was put to one of the group's members, a typical response was given:

> **J:** *"well, places like Bow and Poplar don't really have the same need as Spitalfields,.....and nobody from those areas ever comes to the meetings".*

However there are no local authority representatives from Bethnal Green and Stepney neighbourhoods where most of the work is done. As far as can be ascertained from the group's documentation, invitations to the meetings have never been made to representatives of the neighbourhoods which are the least recognised. When the group was set up nearly all the health authority and local authority staff were based in Bethnal Green and Stepney, and the Health Inquiry report, from which the group was established, concentrated mostly on those areas in the western part of the borough. These factors may partly account for the group's perspective on Tower Hamlets. It is also important to note that the areas that feature strongly in terms of the sense of place of the group are those which are perceived to be of poor environmental quality. Indeed these areas are confirmed to have greater need when indexes of deprivation such as the Jarman ranking are used (Jarman 1983, 1984). However, there are wards in the eastern part of the borough which also have high Jarman scores, yet are not included within the areas where the group's activities take place.

The Globe Town Health Action Area does not have as strong a shared sense of place as the Health Strategy Group. This may be due in part to the lack of cohesion between group members, discussed in the previous chapter. Globe Town as an area was only created in 1987 when the local authority decentralised its services into neighbourhoods. Most of the neighbourhood boundaries follow distinct geographical boundaries such as 'A' roads or waterways. Globe Town, to quote one local authority interviewee, *"is the most*

*gerrymandered of all the neighbourhoods".* Globe Town does not cover one distinct natural community, but is on the fringes of Bethnal Green, and Mile End. Yet from the interviews I conducted all the respondents knew quite accurately the boundaries of the neighbourhood. In addition a MORI poll conducted on behalf of the borough in 1990, found that more residents in Globe Town knew which neighbourhood they lived in than any other neighbourhood's residents. Tuan (1977) explains that the house or street that one lives in is part of a persons intimate experience, whereas the larger unit, the neighbourhood, is a concept. In neighbourhoods other than Globe Town, where natural communities have remained, there has been no need for residents to note which neighbourhood they live in. However, in Globe Town where previously the residents were in Mile End, Stepney or Bethnal Green in long established natural communities, they have noted the new identity imposed upon them, with the loss of their old area.

Despite this awareness of boundaries and what the area consists of, the respondents from this group were less likely to bring up the subject of perception of environment in relation to the borough or neighbourhood, or as an abstract idea. Those respondents who did talk about the subject, found the questions that they were asked difficult to answer, and often took longer to answer, when compared to the respondents in the other two groups. Tuan went on to expand his ideas on larger units or neighbourhoods by stating:

> "The larger unit acquires visibility through an effort of the mind. The entire neighbourhood then becomes a place. It is however a conceptual place and does not involve the emotions".
>
> (Tuan, 1977, P171)

This explains why the tenants were easily able to identify which neighbourhood they belonged to in terms of their knowledge of boundaries and this also applies to members of the Globe Town Health Action Area. Because of the lack of emotion involved, there is no concept of Globe Town as a neighbourhood and a place with specific meaning. This seems

to indicate that the close ties and knowledge which help to foster a sense of place, as yet, have not occurred in Globe Town due to its relative youth as an area, and because the members of the Health Action Area do not operate at the estate based level, but are based within the neighbourhood office, or out of Globe Town. However, recently the Health Action Area has seen some new members who work at the estate based level join, and already in a matter of months there appears to be a much clearer perception of Globe Town as an area, as these community development officers, (as they are termed), are able to inform the Health Action Area much more about what Globe Town is like as a place in which to live and work, due to the knowledge they have gained at a more local level.

The health professionals who attend this group were the least clear about where the boundaries of the neighbourhood were, and this was particularly true of those professionals who had worked in the area prior to its reorganisation as Globe Town neighbourhood, when previously most of Globe Town had been referred to as Bethnal Green. This lack of knowledge is partly because most health professionals work across neighbourhood boundaries, some work on a borough wide basis, and some in localities. In this case Globe Town is part of a locality within Bethnal Green Neighbourhood.

Both the Health Strategy Group and Spitalfields Working Party members were able to talk of specific estates, or areas that they felt had greater needs of a particular type than other areas. In Globe Town, none of the members of the group, other than the local tenants, gave any information about the perceived environmental quality of individual estates or Globe Town as a whole. Most of the local authority officers who were on the steering committee at this time had a neighbourhood wide remit, and were based in the central neighbourhood office. To quote one neighbourhood worker:

> **C:***"The only parts of Globe Town that I know are between the Tube station and here [the neighbourhood office] and the cafe where I have lunch".*

As mentioned earlier this has changed since the interviews were carried out, with the introduction to the steering committee of community development officers who have a much wider knowledge of the neighbourhood. What is interesting though, is that the area around the neighbourhood offices, including the shops, and Bethnal Green Tube Station, were considered by most respondents to be an integral part of Globe Town, and the central location or focus for the neighbourhood. This encompasses the area that was previously the central point of the old Bethnal Green municipal district, an area that was one of the main landmarks within Tower Hamlets. It would appear that the sense of place associated with this old landmark has remained, but that the name of this area has changed from Bethnal Green to Globe Town. Thus the area is not now represented as a sense of place of Globe Town. However as new generations who did not know the former boundaries accept and integrate Globe Town into their lifeworlds, in generations to come it may be recognised as Globe Town proper and not Bethnal Green under a pseudonym.

The Spitalfields working party has a very strong sense of place which is collectively shared by the group. This group is operating at a very localised level, namely a ward, and also has the highest degree of tenant participation of all three groups; these factors evidently contribute to a strong sense of place. Like the Health Strategy Group, its perceptions of Spitalfields are generally of those areas with the poorest environmental quality. Spitalfields borders the City of London, and most of the interviewees felt that the most westerly part of the ward did not have the 'true' identity of Spitalfields. The 'true' identity of Spitalfields according to the respondents are the old parts, consisting of narrow streets, tenement housing, and markets, whereas the western part of Spitalfields is now undergoing major redevelopment, as a result of The City of London's expansion.

> **J:***"Although I know that it is Spitalfields, I don't think of it that way - it's so 'citified' - I don't see that as Spitalfields at all".*

**H:***"The area around Bishopsgate, that's not your real Spitalfields, not any more".*

Not only did the respondents exclude the newer built up areas of the ward, but almost half those interviewed included an estate in an neighbouring ward as being Spitalfields. The estate that they included is a particularly run down, old estate, with a high Bengali population, and many environmental and housing problems, which according to the respondents are the key landmarks that distinguish Spitalfields. The length of Brick Lane was also deemed to be the heart of Spitalfields, when in fact only half of this street actually falls within the ward boundaries. Like the Globe Town group, the respondents mentioned the area around where the working party meets as an important area in terms of their sense of place, and this was particularly true for those who did not work in the ward.

The high tenant participation of this group, and the fact that most representatives from the statutory agencies were frontline or field staff, (that is they are not in managerial positions but are working throughout the ward, mostly at the estate based level), meant that the descriptions of places given were more detailed then those given by respondents in the other two groups, due to the greater degree of knowledge. Shops, buildings and landmarks are particularly important in peoples' descriptions (see Lynch 1960). For example:

**H:***"..the part of Brick Lane from the Bengali sweet shop on the right hand side, up past the brewery to the bagel shop".*

**P:***"along Hanbury Street, past Kingwood house and the Monti [the Montifiore Centre where the group meets] to the junction with Brick Lane".*

Other examples of how respondents' perception of the neighbourhoods and Tower Hamlets as a whole varied can be seen from an analysis of the map exercise. The respondents were all given approximately six minutes to place 60 photographs on a map of Tower Hamlets showing all seven neighbourhoods. In addition to the seven neighbourhoods, there were categories for 'Don't know' and 'Out of Tower Hamlets'. The map exercise highlighted a number of common themes among the respondents decisions on where to place the photographs. These themes include distinct perceptions as to the character of certain neighbourhoods, and the character of the borough as a whole, and also areas which were not well known, or where respondents had no clear sense of place of the area.

There were some photographs that most people located correctly. These photographs had features that could be associated with perceptions of those neighbourhood areas. For example photo 6b (Figure 28), was correctly identified by 8 out of 11 respondents who had the photograph in their sample. The photograph was taken on the Isle of Dogs, and the fact that it shows construction work was a major clue, as the Isle of Dogs was where most new building and major construction was being carried out as part of the development of Docklands.

Photograph 28 (Figure 28) was correctly identified by 6 out of 10 respondents as being Bethnal Green. In photograph 28 the two people in the picture are both Bengali, and they are walking towards an old local authority block of flats; this possibly assisted the decision that the location was Bethnal Green. The sign above the bar may also have provided a clue. Again with photograph 33b seven out of ten respondents correctly identified this picture as being taken in Bethnal Green. From the first set of interviews that I carried out the overall perception of Bethnal Green was that of a particularly run down place, of poor environmental quality. That most respondents selected Bethnal Green with this photograph perhaps has more to do with their sense of place of Bethnal Green then it does with their knowledge of the area depicted in the photograph within Bethnal Green. In fact from the

Figure 28 - Photographs 6b (Orchard Place, Isle of Dogs) 28 (Delta Street, Bethnal Green) and 33b (Bacon Street, Bethnal Green).

transcriptions of the exercise, nobody identified the name of the street depicted in this photograph, or its whereabouts in relation to other landmarks.

Photograph 10b (Figure 29) was correctly located in Bow neighbourhood by 6 out of 10 people, the other 4 respondents thought that it was not in Tower Hamlets. Again I think that this photograph was correctly placed due to the overall perception that is given to Bow neighbourhood by public health workers as being an area with good quality terraced housing, with a pleasant environment rather than being due to knowledge of its actual location within the neighbourhood. Four of those respondents who correctly identified its location as Bow, wrongly thought that it was in Tredegar Square[11]. The other two did not give a named location.

Photograph 20 (Figure 29) is an example of a photograph that nobody correctly identified *"god,....that could be anywhere"*. This photograph is very hard to distinguish, and was placed in the "don't know" category by 4 of the 9 respondents who had this photograph in their sample. Photographs 7b, 14b, and 8b (Figure 30) were also all wrongly identified by the respondents who had them in their sample. These photographs show a variety of settings, but do not present a clear enough image to be located within a neighbourhood. There were also no clear patterns as to where respondents thought these photographs should be.

Photographs 27 and 40 (Figure 31) are two examples of photographs that were considered not to be in Tower Hamlets. Three respondents felt that this photograph was not in Tower Hamlets because "we" did not have a large French population, and there was a

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[11] Tredegar Square is an area of Bow which consists of the most expensive housing in Tower Hamlets. It is made up of a Square of approximately 40 five storey Victorian houses. In the centre of the square is a park for the residents. It is well known throughout the borough as being the most affluent area.

Figure 29 - Photograph 10b (Coburn Street, Bow) and 20 (Roberta Street, Bow)

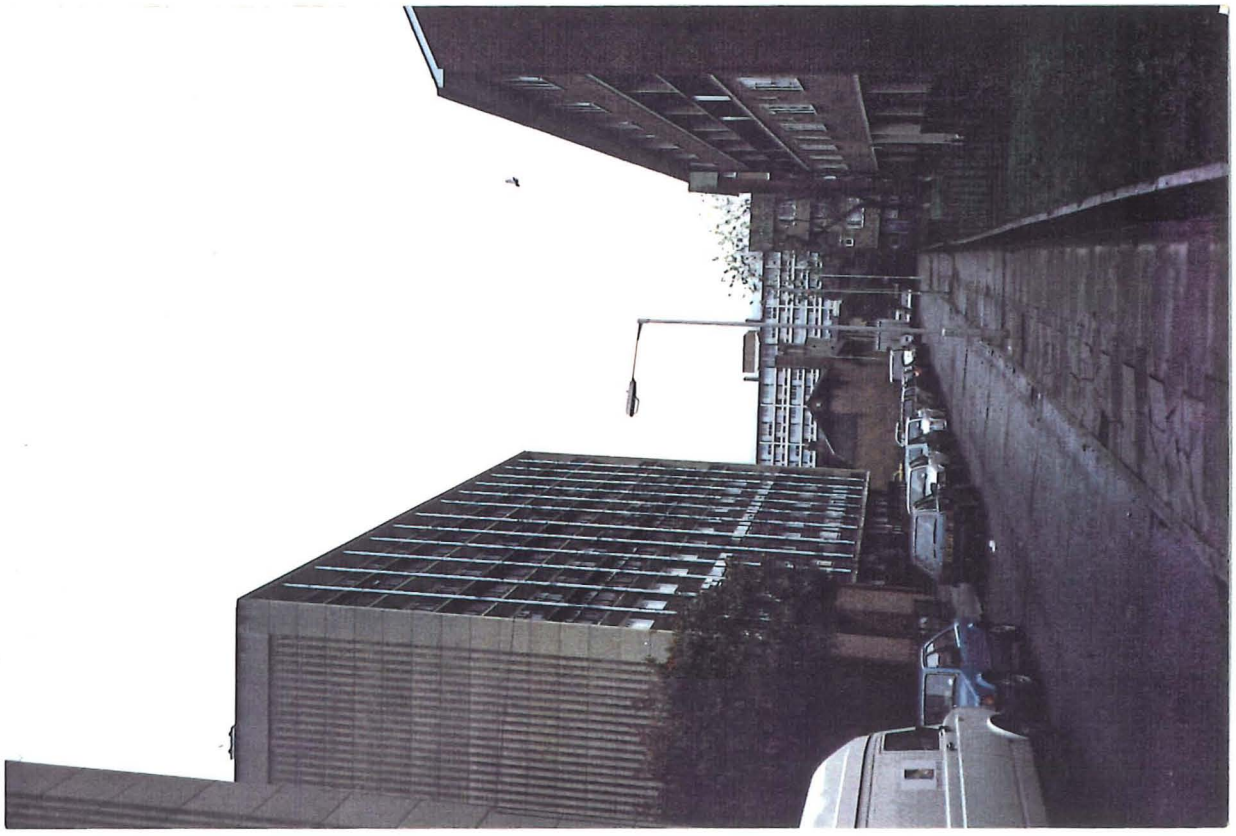


Figure 30 - Photographs 7b (Canrobert Street, Bethnal Green) 14b (Solebay Street, Stepney) and 8b (Brewhouse Lane, Wapping).

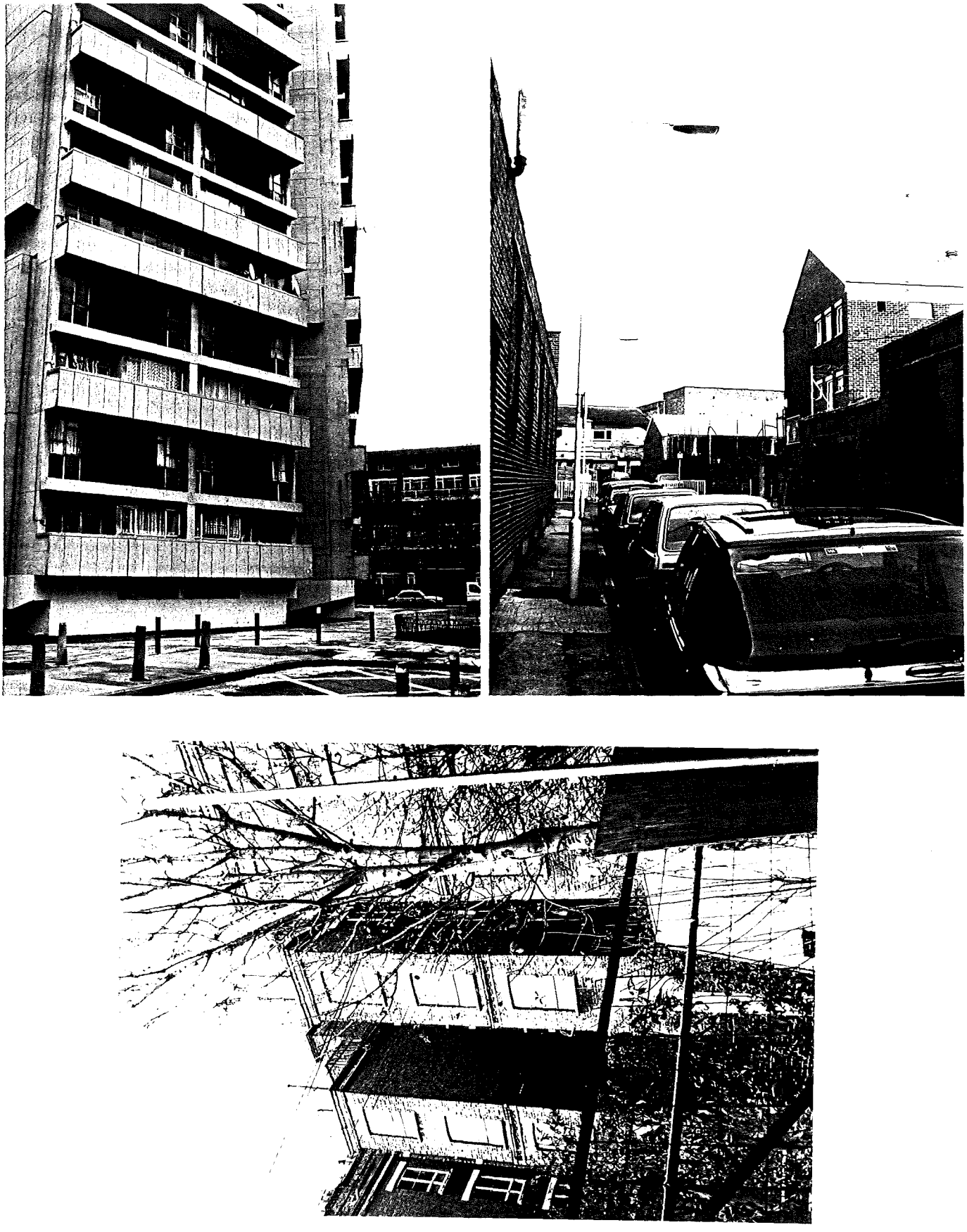


Figure 31 - Photographs 27 (Paton Close, Bow) and 40 (Redchurch Street, Bethnal Green)


French mural on the wall. The lamp post in this photograph is a good clue that the photograph was taken in Bow, as Bow is the only neighbourhood in Tower Hamlets to have lamp posts such as these. Photograph 40 was felt not to be in Tower Hamlets because it is "too posh for Tower Hamlets". In fact the picture was taken in Spitalfields, Bethnal Green Neighbourhood, and is a renovated silk weaver's house. This highlights the recurrent theme that those working in Tower Hamlets, do not perceive the area to have a good environmental quality, or a good standard of 'desirable' housing. Photograph 40 is particularly incongruent with the image of Spitalfields as the most run down part of the borough.

Photographs 21b and 37 (Figure 32) are examples of photographs that were consistently placed by the majority of respondents in a neighbourhood other than the actual location. Photo 37 was actually of Bethnal Green, but 6 respondents out of 9 felt that it was taken in Wapping. Similarly photograph 21b is actually of Wapping but 5 out of 11 respondents thought it was of Bethnal Green. No clear pattern could be distinguished from the results of the other six respondents. It appears that many of the respondents felt that Bethnal Green and the north part of Wapping (out of the Docklands Development area) were very similar in character. Both of these areas have large inter-war council estates which are predominantly rented to Bengali residents, and a high number of run-down Victorian premises, as well as some older buildings of historical interest.

Photographs 20b and 15b (Figure 33) are photographs taken in Poplar neighbourhood, but both were considered by most people to be of the neighbourhood of Stepney. While placing these two photographs, 4 respondents commented that "it could be Stepney or Poplar", which points to these two neighbourhoods being perceived in a similar way. One respondent also said:

C:*"If it's modern council housing, the chances are its Poplar or Stepney, and if it's old its Bethnal Green or Wapping".*

Figure 32 - Photograph 21b (Scandrett Street, Wapping) and 37 (Chance Street, Bethnal Green).

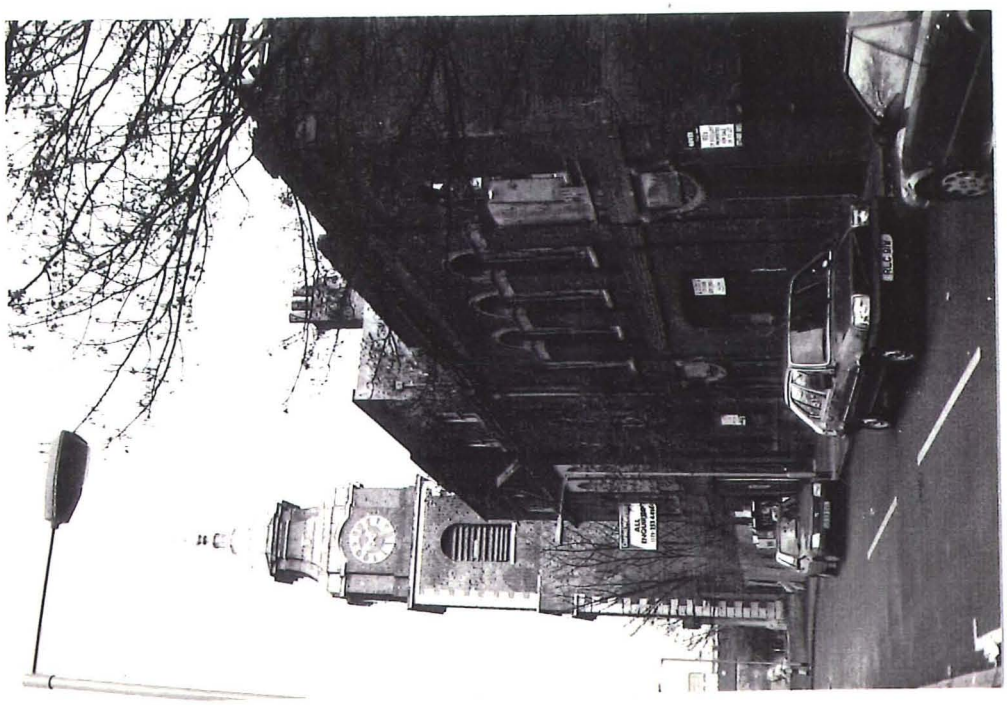


Figure 33 - Photograph 20b (Southern Grove, Poplar) and 15b (Knapp Road, Poplar)

Photographs 5 and 7 (Figure 34) are examples of photographs which were considered to be of Bow, but were actually from 'out of Tower Hamlets' and Poplar respectively. The respondents were very sure that this type of housing had to be in Bow, or not in Tower Hamlets. The sense of place of Bow having a better environment in terms of the quality of housing is very strong, but in fact, Bow has a high number of local authority dwellings. Out of approximately 5,600 households registered on the electoral register, 4,623 are local authority owned properties. The photographs taken in Bow which were of local authority housing, were considered to be in Poplar neighbourhood. Photograph 37b (Photo of a twenty storey tower block in Bow) is a good example of the type of photograph that was not included as being part of the collective identity of Bow neighbourhood.

The photographs that were considered to be in Poplar neighbourhood were very distinctive, and can be broadly categorised into two types either: modern (1950s and 1960s) local authority housing both low and high rise, or a mixture of housing and light commercial/industrial units. Yet in two thirds of the cases the respondents were incorrect about their identification of Poplar .

Some neighbourhoods were more often correctly identified than others. For example the neighbourhoods of Bethnal Green and Stepney had more than half their photographs correctly identified. In Stepney neighbourhood at least four of the photographs which were correctly identified were particular landmarks such as the Stepping Stones City Farm, two pictures of the green off Harford St, and Stepney High St. In Bethnal Green the photographs that were correctly identified are those with a poor environmental quality, depicting derelict or run down housing, examples being photographs 30, 28, 41 and 33b. The photographs taken in Bethnal Green with a more positive environmental quality were the photographs that were not correctly placed, examples being photographs 40, and 16b (Figure 35). These figures tend to support the material gathered from participant observation and the first set of interviews, that most of the public health work that is carried

Figure 34 - Photographs 5 (Roding Road, Hackney) and 7 (Campbell Road, Poplar),

Figure 35 - Photographs 40 (Redchurch Street Bethnal Green) and 16b (Turin Street, Bethnal Green).

out in Tower hamlets occurs in these two neighbourhoods, and that the common image of Bethnal Green and Stepney is one of poor environmental quality, and therefore the greatest public health need. However conversely, these figures could be a reflection of the strong sense of place of these two neighbourhoods.

The neighbourhoods of Poplar, Globe Town and Bow were fairly evenly matched in terms of the number of photographs correctly identified in the map exercise. This again corresponds with the findings of the interviews and documentation of the groups, that these neighbourhoods are not well known, and that the public health workers sense of these neighbourhoods is different from the actual formation of the neighbourhood in reality. Wapping neighbourhood was poorly recognised, with very few photographs being correctly identified; most of the workers who did 'venture' into Wapping, did so only to attend meetings which were on the border with Stepney, and so very few public health workers actually travel throughout this neighbourhood. There was also the perception that Wapping consists of a lot of new housing, or converted warehouses, with little local authority housing. This perception was also true of the Isle of Dogs, yet this neighbourhood did reasonably well in terms of the number of photographs correctly identified. However, this may be due to the Island having particularly distinct types of housing and other distinguishable landmarks, such as the 'Blue Bridge', which featured in one photograph, the Docklands Light Railway which featured in another, and Canary Wharf which was in the background of a third. The photographs of the Isle of Dogs that were incorrectly identified were photographs that consisted mainly of semi-detached and terraced housing, areas not part of the new development of the Docklands.

Only three neighbourhoods had photographs that were hard to distinguish in that they did not match a sense of place for any of the respondents, and were therefore not placed by a majority in any one category. The neighbourhoods involved were Bethnal Green, Bow, and the Isle of Dogs. As we have seen from other material, these three neighbourhoods did have a particular sense of place that is shared by the respondents. The photographs that

were not placed into any distinct category, did not have any factors that particularly linked them, other than that they contain no landmarks or easily recognisable symbols, and the content tended to be housing estates, that are universal in design. As one respondent remarked on seeing one of these photographs:

**R:***"Well, that could be any estate, anywhere in the country".*

Many photographs were mistakenly considered to be of neighbouring areas. For example, photographs placed in Bethnal Green were of neighbouring Globe Town, photographs placed in Bow should have been in Poplar and Globe Town, photographs placed in Poplar were of Bow and Stepney. It is also interesting to note that most photographs that were placed in the out of Tower Hamlets category should have been placed in Bow or the Isle of Dogs, the type of photographs that were considered to be of Bow were very similar to the type of photographs placed out of Tower Hamlets which were of the Isle of Dogs. Bow was perceived to have good quality terraced housing, which is comparable to similar housing out of Tower Hamlets. The Isle of Dogs was not considered to have good quality old terraced housing and therefore the photographs were put out of Tower Hamlets. The photographs that should have been placed as being on the Isle of Dogs, all consisted of rows of pleasant terraced pre-war housing.

As mentioned previously when considering the results gathered from the participant observation, and the interviews, neighbourhoods had a particular sense of place for the public health workers, and also certain other landmarks were cited as examples of locations with particular significance in terms of place. One of these areas mentioned by a number of respondents was Brick Lane which has a definite sense of place, in part created by the media, and in part by some of the shop and restaurant owners. It has often been referred to as the heart of the Bengali community and by the media as Bangla Town. Photograph 54 (Figure 36) shows a picture of Brick Lane which is hard to recognise. In fact none of the respondents identified this photograph as Brick Lane, and apart from myself only one other

Figure 36 - Photographs 54 (Brick Lane, Bethnal Green) and 35 (Arnold Circus, Bethnal Green)


person placed the photograph in Bethnal Green. After the exercise, it was mentioned to those respondents who had photograph 54 in their sample, that it was of Brick Lane, and they were all very surprised. Many people had never seen the flats before, and two people thought that there was a mistake. The photograph was obviously incongruent to the general sense of place of Brick Lane, particularly as it portrayed a clean reasonable standard of housing.

Another interesting anomaly related to not being able to fit the image that the photograph presents with the image in the respondents mind, occurred with photograph 35 (Figure 36), a picture of a bandstand in a park. A number of people commented on what a beautiful picture it was, yet four respondents said that although they liked the picture, they would not like to live in the area, as they had identified the location of the picture, and the area was "not nice". Two of the respondents went on to say that the bandstand did not look like that in reality, and that the camera had got its better side:

> **J:***"35 looks very nice - although because I know where it is, I know it isn't as nice as that".*

> **R:***"If I didn't know where this was on the Boundary Estate, and I thought it was a nice little environmental feature in the middle of a nice area, it would be really nice, especially if it was in Oxford or somewhere".*

What is intriguing is why the content of the photograph is not considered nice if the viewer knows that what is around it is less pleasant. This illustrates clearly how sense of place contains more than just the physical features of an area. Sense of place also encompasses social relations, emotions, and instincts. It appears that it is not considered possible to have a small enclave of beauty in an area considered bleak, but rather that the beauty must be dismissed, and the ugliness of the surrounding area noted. This is an example of an activity that frequently occurs amongst public health workers and those workers concerned

with the environment, that the negative aspects of the physical environment are given priority to the exclusion of most of the positive aspects of that environment.

## 9. Conclusions

There are four main conclusions that can be drawn from the analysis of sense of place and public health work in Tower Hamlets One of the main points that has been demonstrated is that sense of place is an important component of decision making, and also an important part of the way that decisions are reached concerning appropriate places in which to work. Public Health work that is carried out is focussed on those areas where there is the greatest perceived need, and the greatest need is strongly influenced by the collective sense of place of the group. In most cases, the groups were fairly accurate at identifying areas where there were particular needs that can be addressed by improving the public health input. This was not necessarily a difficult activity in an area like Tower Hamlets, but the problem that arises, is that the same specific areas within the borough tend to receive all the attention once they have been 'discovered'. Tower Hamlets is one of the most deprived inner city areas in the whole country, and it is possible to go into any neighbourhood of the borough and find an estate that is run down and in need of a significant public health input. However, certain neighbourhoods are focussed on more than others due to the workers perceptions about these neighbourhoods, and therefore it is only in these neighbourhoods that the 'run down' estates are sought.

For example Bethnal Green was perceived to be the poorest area, as has been demonstrated in several ways in this thesis. Participant observation at the meetings of the groups, particularly the Health Strategy Group and Department of Public Health, but also at other borough wide meetings, points to most of the work and strategies being focussed in this area. Certain estates in Bethnal Green (Chicksand, Codrington, and Brune House),

are used as examples of the 'greatest need' in a variety of aspects, with a number of projects being carried out in these estates. These same three estates were often held up in meetings as examples of the poor quality of environment of the area. It is interesting to note that these three estates are predominantly populated by Bengali residents, who are economically and socially the poorest community in the borough. These estates were also the main focus of the Spitalfields Working Party covering one ward of Bethnal green neighbourhood, they are the estates that are used as the background setting for interviews with newspapers and television. These estates conform to the collective identity of a poor quality inner city environment. As we have seen in the photograph exercise, the majority of respondents were quick to place the photographs they identified with poor physical, social and economic environment in Bethnal Green, and in the interviews with the members of the public health groups, Bethnal Green was the most commonly mentioned area, when giving examples of where work was being carried out.

This is not to deny that Bethnal Green does not have these perceived problems, but Bethnal Green is not alone in Tower Hamlets in being an area with significant public health need. There are pockets of deprivation throughout all seven neighbourhoods in Tower Hamlets, just as there are pockets of good quality housing and open spaces, in all seven neighbourhoods. Familiarity with a place strengthens ones sense of place. As the place takes on more character, symbols and landmarks take on new significance, and most importantly knowledge of the area increases. Thus the more that work is concentrated in Bethnal Green, the more focussed the collective sense of place of Bethnal Green as being a poor environment will become, perpetuating the cycle of more work, greater perceived need from sense of place, leading to more work.

The Spitalfields Working Party has justification for its focus on this area as it only represents this ward, but as mentioned earlier in this chapter there are areas that are outside of the ward that are perceiveed to be deprived (Codrington Estate) and that are included yet are not within the boundaries. Similarly there are areas which are perceived to be

environmentally 'sound' (the new office developments) within the boundaries which are ignored. The Health Strategy Group, Department of Public Health and other borough wide organisations, do not have the same justification for concentrating most of their activities in this area. However in the case of the Health Strategy Group, the fact that the group is located in this neighbourhood increases the sense of place and familiarity of the group's members. Because the Health Strategy Group has a number of projects in Bethnal Green, relationships have been built up with officers of the local authority working in this area, and it is convenient for the Health Strategy Group's workers to operate in this area due to the close proximity with the office.

A second conclusion is that among the public health workers there is a shared sense of place in terms of the perception of the borough and how that is portrayed to outsiders, particularly to those in the same field of work, or to those perceived to be within the new public health movement. The sense of place that is portrayed is homogeneous across the borough, and is one of negative environmental features that consists of characteristics such as: poor quality local authority housing; a high proportion of tower block residences; little greenery; rubbish; and unattractive scenery. To summarise, the perception of Tower Hamlets is a negative sense of place, when presented to outsiders. This implies that there is some vested interest for the public health workers in reinforcing the negative image of Tower Hamlets, which may result from their concern to have a permanent supply of work. The groups as a movement, hold up a collective vision to which the members can all unite around. By emphasizing the negative aspects of the borough, the public health workers in Tower Hamlets are saying to others who work in public health outside the area, that working in Tower Hamlets is far harder than anywhere else because of the greater need, and it gives them a tool for arguing for increased resources. Those involved in public health in Tower Hamlets, engage in a form of 'inverted snobbery' with people from outside the area by portraying an image of Tower Hamlets as being a difficult public health environment to work in. It also allows the workers a safety net, in that they have an 'excuse' of having more work to do, if they do not appear to be achieving the same amount

as workers from different areas. By concentrating on the negative qualities of the environment, the groups ensure that they have a reason to be working, and a demonstrably higher public health need. This perpetuation of Tower Hamlets as having a poor quality environment also serves as an asset when seeking funding from agencies outside the borough who have been influenced by the portrayal of the area by the media and publications written by professionals from within the health and local authorities and the voluntary sector.

The third theme to draw from this chapter is that within Tower Hamlets, the sense of place of different areas and neighbourhoods varies. Those areas in which the most public health work is carried out have the same negative characteristics ascribed to them as the sense of Tower Hamlets as a whole. However, areas that are not part of the arena of public health activity, particularly those areas to the east and south of the borough, are perceived to have a more positive sense of place, or as in the case of Wapping, no clear perception. Linked closely to this positive environmental quality and sense of place is the belief that there is no real public health need as there is in the neighbourhoods in the West of the borough. As we have seen, this perception is not founded on any objective criteria, and many of the areas in the East and South part of the borough share similar poor quality environments to the West. The one exception to this view, is when 'outsiders' comment on the fact that there are certain areas of Tower Hamlets which have less need. Then a united defence is made that Tower Hamlets is homogeneous throughout, with all areas being of a poor environmental quality.

Finally at the individual level there are obvious differences in sense of place that are based on the experiences of the individual. However, there are certain elements that were common between the majority of those interviewed. One implication of this finding is that there are particular kinds of people who are engaged in public health work, and therefore the similarities or group sense of place are because the individuals concerned are self selecting, and tend to be the same type of person. Another explanation is that the

experiences gained in working on public health issues in the area have influenced the individuals concerned, that the common shared sense of place is something that is negotiated through the activities and experiences that the groups enter into. The people working in public health in Tower Hamlets present various combinations of the above. However, where the experiences gained whilst working in public health issues are the main factors contributing to the common sense of place that has been shown to exist, then that sense of place will be self perpetuating in the same form, as the perceptions of the area are used to formulate the agenda for new work.

It may be that in order to ensure that public health activities take place throughout the borough operating within the new public health movement, new groups need to be formed in those areas currently marginalized by the present groups and their members. Otherwise it may be necessary to encourage the groups to start immersing themselves in areas other than those they currently focus upon, in order to gain a more comprehensive picture of the borough which might in turn alter their perceptions of other places. There is no guarantee that if new groups start operating in the neglected neighbourhoods that the situation will be resolved, because as we have seen in Globe Town neighbourhood, the Health Action Area as a whole, had a particularly poor sense of place, and efforts were not concentrated uniformly across the neighbourhood but in areas that had some familiarity to the groups.

New people joining the groups, and in particular those from other areas within Tower Hamlets, might help to re-negotiate the common sense of place for public health work by bringing new experiences and new areas for attention to the groups' notice, which will enable them to encompass more of the physical area of the borough. If the new public health is to grow as an urban social movement and is to gain momentum, great importance rests upon groups working across the borough, in order that new members can be mobilised into action, and that Tower Hamlets as a whole can be improved, rather than only in those pockets of the area that are at present sensed to be in most need.

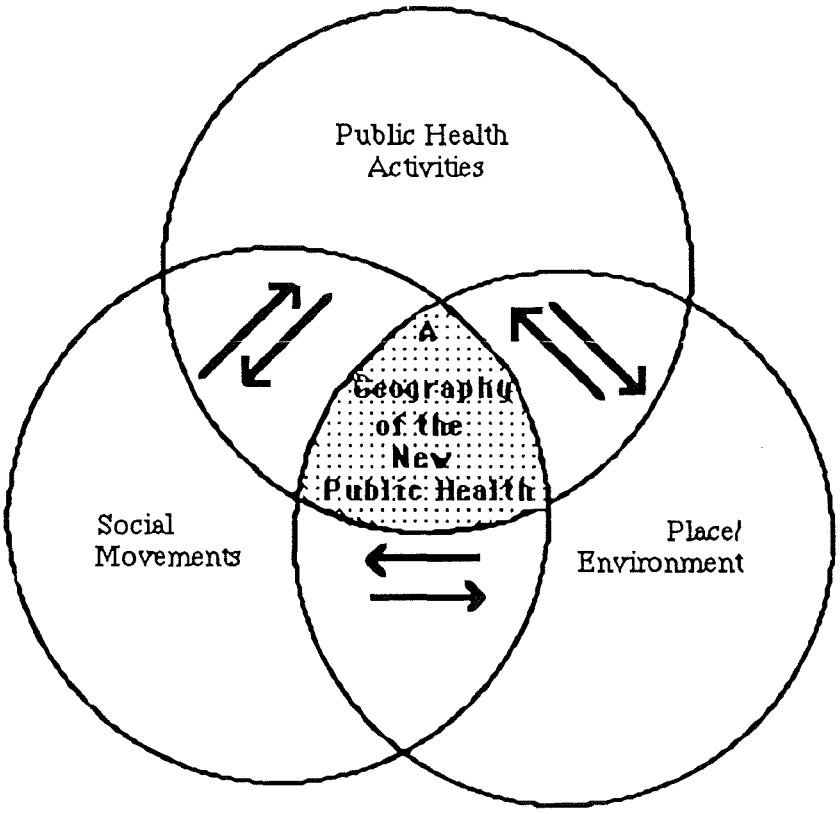
## CHAPTER 8

# A GEOGRAPHY OF THE NEW PUBLIC HEALTH

This thesis has examined a geography of the new public health, through an analysis of the organisation of public health activities in Tower Hamlets, East London. It has demonstrated three things. Firstly, how an understanding of the new public health can broaden the focus of research within medical geography. Secondly, how the new public health as an urban social movement has a future in the social reforms taking place in cities across the world, and finally, that sense of place (as a physical, social and economic environment) is one of the key ways that the work of the new public health movement is shaped. In the introduction to this thesis, the hypothesis laid down was that in order to establish and understand a geography of the new public health, the balance between the essential elements of public health, place and urban social movements needed to be analysed in depth, with a particular focus on their interrelationships, and relative contributions to the new public health movement. Figure 36 shows this relationship in diagrammatic form.

In discussing and concluding what a geography of the new public health is, the balance between these elements will be analysed by re-examining the evidence offered from the empirical chapters of this thesis, and by reviewing the main arguments put forward in the literature related to these three elements. From this discussion conclusions will be drawn about the present and future position of the new public health, and what a more developed geography of the new public health might have to offer an evaluation and future direction of public health; and conversely what the new public health might have to offer medical geography. In addition this chapter offers a critical reflection on how the research was undertaken, and on the constraints, resources, and methodology that helped to shape the thesis.

**Figure 37** **The Key Elements of A Geography of the New Public Health**



## 1. Public Health

Public health is the most spatial form of medicine, in that public health is primarily concerned with the health of populations or communities within specific locations, unlike most other forms of medicine which are concerned with the health of an individual, or more usually the ill-health of an individual. For this reason it is crucial that public health is explored from within a geographic framework, since the central focus of geographic inquiry is to explain the relationship between elements and the locations in which they occur (Peter Haggett in Johnston et al, 1986). Not only is public health focussed on whole populations, but one of its central concerns is how the economic, social and political systems in operation affect public health at both the macro (international and national) and micro (local and community) levels. This is particularly true of the new public health movement that has developed during the last decade, whose primary aim is to link the structural processes of economic, social and political reforms to improvements in health. The new public health is far more than a division of health care provision, in that it is a holistic approach to health and encompasses the World Health Organisations definition of health as "complete physical, social and mental well being" (WHO 1985).

The links between the new public health and the old style '19th Century' public health, are important in analysing the development of public health. However, it is important to state clearly that although the new public health has borrowed heavily from the ideology and principles of the old style public health, public health in the past was much more narrowly interpreted with an emphasis on disease control, epidemiology and environmental health. In addition, the people who were the driving force behind the legislation and improvements made to the public's health in the nineteenth century were not from the communities most at need, but were from educated and privileged backgrounds acting on behalf of the poorer communities (Holland et al 1985). Although portrayed as an urban social movement, the old style public health was not an urban social movement in the context of the definitions advanced by writers on modern urban social

movements (Lowe 1986, Dunleavy 1980, Pickvance 1985), because its organisation was not from the community level, and although it was organised around issues of collective consumption, its focus was narrow; it was place specific in that most activities were carried out in the inner cities, but, activities were increasingly directed towards population groups such as mothers, the elderly or children, rather than particular community environments (Watkin 1978). While the old and the new public health have in common the links between political reform and social action, the new public health has a much wider scope of activities, and is led and mobilised from the community who identify their own needs and priorities. This is in comparison to the old style public health, which was very much controlled by government legislation. The developments in public health in an historical perspective can be analysed in terms of how the social action informing public health activities has been organised in time and more importantly in space; in other words how the public health movement of the nineteenth century has developed into and compares with the public health movement of the late twentieth century. This thesis has concentrated on public health activities in the 1980s and 1990s with a brief history of the developments over the last century. However, there would be merit in analysing the historical development of public health from within a geographic framework of research in more detail. This was not possible within the limitations of this thesis, but would be a valuable contribution to understanding the impact of public health on society through time and space.

The new public health is concerned with health at the macro level, not just in terms of the policy changes that need to be implemented throughout the whole of society, but also in terms of shifting the emphasis from treating and curing illness and disease to preventing ill health and maintaining and promoting good health. In bridging this gap between curative and preventative medicine, the role of health professionals, and people in positions of power and influence within the medical profession, are particularly important in affecting change at a national or macro level. Other factors contributing to the influence public health has at the macro scale include public media representation of

the new public health. This has been done through publications of groups such as The Public Health Alliance, National Community Health Resource, and the Radical Statistics Health Group in addition to journals such as Critical Public Health. The publications of these groups in contrast to the WHO which is often perceived as being orthodox, offers alternative perspectives and methodologies for public health, yet they complement one another as they both promote similar views of the new public health.

In chapter two the key concepts of the new public health were identified as public ownership, public responsibility, and public accountability, these concepts are similar to the WHO terminology of empowerment, community participation, and multi-sectoral collaboration. These phrases and terms can easily appear to be nothing more than rhetoric. However, as we have seen from an analysis of the three groups in Tower Hamlets, the most successful and organised group (the Health Strategy Group) in terms of grants received, number of projects, accountability and collective strategy for the future, is the group that was also most successful and organised in terms of community participation, empowerment and multi-sectoral action. For this group the terms are not empty, but are guiding forces in the development of this local expression of the new public health movement. The interview material used in chapter five demonstrates that the members of the groups are all aware how important these aspects of participation, empowerment and working together are, and they also acknowledge that the areas in which they are failing are because of deficiencies in these same aspects.

Within this thesis there was an analysis of community participation within the groups, and the role of different participants according to their backgrounds (statutory or voluntary). The role of empowerment was looked at through an analysis of community development. However, an emphasis on empowerment in its broadest sense was not a key theme of this research. There are many different ways in which local people become involved with health issues, which all have elements of empowerment. In this research most of the people involved were employed in some capacity to do with health or local

authority service provision. However, the people participating in the three research groups in this thesis were doing so because the groups empowered them to achieve activities that they could not within the contexts of their ordinary work experience. It is within this interpretation of empowerment that most of the analysis in this thesis has taken place.

However, there is also the interpretation of empowerment in terms of numbers of people who have been mobilised around particular issues. For example many hundreds of people were involved in the campaign to save the Mile End accident and emergency department from closing. There were a number of public meetings and marches. Similarly, there were well over 1000 people who demonstrated on the march to reinstate Dr Wendy Savage the consultant obstetrician who was suspended for allegedly being a danger to her patients. Although in terms of numbers a great deal more people were involved in these campaigns, it is important to note that their involvement was over a particularly short period of time about specific issues that lent themselves to a 'campaign' rather than concerted action over a long period. They were not directly about issues of improving health status and demonstrating different ways of working. They were specific campaigns to prevent loss of particular types of service.

The new public health is not about generating large numbers of people to mobilise around the issues, it is more concerned with empowering individuals to act on behalf of themselves and their health. Thus the role of the three groups in Tower Hamlets is in empowering individuals that they come into contact with through the various activities and projects that are run. Through the three groups, a large number of people have been empowered in very different ways, for example the globe Town Health Action Area health desk worked with individuals about specific diseases, the Spitalfields Working Party worked with local tenants empowering them to consider how to improve their housing and rid themselves of pest infestations, and the Health Strategy Group empowered local Bengali residents to apply for jobs within the health service. These are

only a few examples of how the wider networks of the new public health have empowered people.

Empowerment is clearly one of the most important achievements of the new public health movement. I did not focus on how the groups empowered individuals, because this thesis was focussing on the three groups, and how they were constructed and how they worked. However this thesis did concentrate on an essential component of empowerment, namely community participation. It is arguable that community participation and empowerment are interchangeable terms, especially at the group level. However, if medical geographers are to take up the challenge of looking at health in the context that it occurs, then empowerment and community participation in health will be of vital importance to an increased understanding of the key issues.

Not only is the new public health deserving of a geographical analysis, but such an analysis can also help to broaden the research focus and develop a new framework for medical geography. Much of the work traditionally set within the field of medical geography has concentrated on quantitative aspects of analysis (Phillips 1981). The focus has been on provision of services and care, distribution of resources, and patterns of disease. Within the context of the new public health, medical geography has opportunities to explore the relationships between health and society, and to make comparisons both inter, and intra-nationally, and to answer the pleas that have been coming from medical geographers to examine health in terms of the totality of society (Eyles and Woods 1983, Jones and Moon 1987). Public health is the ideal topic for examining health in the totality of society, because public health is inextricably intertwined with all aspects of society: with social, economic and political factors; with the physical environment, home, workplace, and school; with health resources, allocation and intervention. It is difficult to examine health in its totality without considering public health, because any other sub-division of health (e.g. disease groups or population groups) or health care (e.g. hospital provision, primary health care), ignores the role of society in this holistic sense. Of

course there is value in analysing these sub-divisions, and this has been the predominant field of most medical geographical studies, but without wider analysis which includes the context of all health and ill-health, in terms of an analysis of society and societies' health, there is no framework or context to situate these other studies in.

Medical geographers must re-focus their attention on the wider questions concerning health and its relationship to society before returning to the intricacies of specific sub-topics. Medical geography in the past has focussed its attention on patterns rather than processes. In order to develop a medical geography which incorporates a strong theoretical base then it is necessary to consider the arguments concerning the development and relationship of health to the society we live in by examining the processes that are involved. It is not enough to examine the patterns produced of health status or health service provision, attention must centre on how these patterns arose. In order to answer the questions as to how the patterns arose, there is a need to examine the criteria and their context, namely public health. Questions centred on resources for health must look at how and why resources are distributed in the way they are, rather than just where. Similarly research focussed on the distribution of disease should return one stage to evaluate the processes that have contributed to the patterns of disease.

The most comprehensive way that medical geographers can approach these public health research questions is by developing a framework that concentrates on processes within public health rather than products. As documented in this thesis, a great deal of the work carried out by medical geographers in the past was concentrated on positivist methodologies, however over the last decade authors such as Cornwall (1984) Donovan (1986) and Gesler (1992) have used more qualitative approaches. Medical geographers need to build on their work, but expand the topic area to include an analysis of health in its societal context. A geographical analysis of the new public health provides medical geographers with the opportunity to develop new methodologies for research and also to

work more closely with other geographers and social scientists, who are working from within more qualitative approaches.

## 2. Urban Social Movements

A further reason for an analysis of the new public health from within a geographic framework is that it is operating on a number of different geographical scales, from the community, city, region, national, continental and global dimensions. As we have seen, as an urban social movement, the new public health is almost unique in that it is organised at the local level, and it at this level that the concentration of strength and power is. Yet, there is also more formal organisation at the international level through the relationship the new public health has with the developments in the Healthy Cities project and Health For All 2000. In Britain, the new public health has very little interaction with the national government unlike other large urban social movements in existence such as the Campaign for Nuclear Disarmament, or the Welfare Rights movement (Eyerman and Jamison 1991), yet it has an international and global perspective through its links with WHO. This raises issues about the extent to which urban social movements can have influence over the prevailing political ideology (Hasson 1992). Through the auspices of the World Health Organisation, the new public health movement is having a global impact (although the focus is much more in the developed countries of the world), and because of the nature of public health this means social, political and economic reforms, are taking place as a result of public health reforms. For example issues relating to inadequate housing, unemployment, crime and poor quality environments are all being tackled through the auspices of initiatives such as Healthy Cities or HFA 2000 - expressions of the new public health movement. A direct relationship is being made between these issues and health, and the new public health is attempting to reform the health of different societies, by tackling these issues directly and encouraging change at all levels. It is these reforms that distinguish the new public health as an urban social movement, as opposed to a

protest movement which is reactive against government policy. These are not reforms that will change the political structure of countries by causing the downfall of governments, but they are reforms that have the power to influence and guide the direction of policy.

One of the key roles that the new public health movement plays is in demonstrating good models of concerted action on health. As these models are replicated by various local expressions of the new public health movement, and adopted by the local statutory authorities, so the new public health is able to influence government at a national level. There is evidence for this happening already in Britain. Although Britain was a signatory to the World Health Organisation Health For All by the year 2000 initiative, no formal national activities or directives were set in place for achieving the 38 targets set down by the European region. As has been described in this thesis, Health For All was adopted by groups where there was enthusiasm, commitment and knowledge. This has led to uneven and haphazard development of the initiative, certain regions and communities began to channel all their working activities towards working within a Health for All framework, the cities of Liverpool, Sheffield and Birmingham, have used a great deal of their resources from the health authority, local authority and private industry in order to operate within this framework (Tsouros 1991). Within the areas where Health For All was being taken on board, within this country and others in Europe, the issue of inequalities in health began to be addressed, but for those areas where Health For All was not being implemented, the issues of inequalities in health were only highlighted but not acted upon.

Since the period of research for this thesis ended, the British Government has introduced national legislation on public health, that addresses some of the key principles of the new public health movement as developed by the WHO. In the summer of 1991, the Government published a document called 'The Health of the Nation' which was a consultative (green) paper sent to all health authorities in England and Wales to set out the guide-lines for a health strategy for the country. This was revised into a White Paper in

June 1992 (HMSO 1992). The document contains targets similar to those set down by the European region of the World Health Organisation and also discusses the concepts intrinsic to the new public health movement such as community participation, empowerment and multi-sectoral action. The targets set down in 'The Health of the Nation' are much more selective than those of the HFA 2000 initiative in Europe and are based on the major causes or morbidity in this country which are amenable to intervention. The five areas for the targets are Accidents, Cancer, Coronary Heart Disease, Sexual Health and Mental Health. The 'Health of the Nation' targets are not as comprehensive as the HFA targets; the targets cover many areas to be met by the health service as opposed to multi-sectoral action. In addition the target levels follow the natural progression or current trends. For example, one target related to reductions in coronary heart disease and cancer, aiming to reduce the number of people who smoke, has been set on a line of the natural progression of the decline in smoking if no new intervention were to happen. Thus the target should be achieved whether or not any concerted action is put towards meeting it. Despite these criticisms, 'The Health of the Nation' is a start towards formalising a national policy which takes into account the need for multi-sectoral working that has been successfully demonstrated by the new public health movement in the informal sector in this thesis.

The Health of the Nation initiative was not the result of active campaigning and lobbying on behalf of the public health groups that make up the new public health movement, but rather a realisation by the government that they were being left behind. The new public health movement had grown to such proportions that it was taking decisions and implementing initiatives on a far wider scale than had been envisaged. It also became apparent that the prevailing culture and ideology of health professionals, health care consumers and the population at large, towards health and health care provision, had changed.

The reason why the new public health movement has been able to implement initiatives on such a scale is because its action has been implemented by small groups, working at the local level. Groups like the Globe Town Health Action Area, the Spitalfields Working Party and particularly the Health Strategy Group, are in an ideal position to implement and make changes to the publics health within small localities, working specifically to the needs of the local community. As has been demonstrated from the empirical work in chapters five, six, and seven their knowledge of the places in which they are working both in terms of the physical, social and economic environment and the key people and resources, and their unorthodox, un-bureaucratic and collaborative ways of working enable them to make progress in areas that the statutory authorities can not. The groups working at the local level that together constitute the new public health movement, are mainly working from within a community development approach. This approach has its key in understanding the culture of the local community in order that activities are tailored for that community (Rosenthal 1983), and it ensures that the movement has a strong and cohesive base built on local needs but with a shared vision of the new public health with groups throughout the world.

The significance of a number of groups working around public health issues is that each could be seen to be a unique urban social movement, which is part of the wider movement of the new public health. There cannot be one easily definable movement for the new public health because at the local level the components are so different, and as we have seen this is essential in order that the groups can tackle issues of significance at the local level. It is useful to talk about the or a new public health movement in order to identify and nominate the wide range of groups working in this field, and to bring them together to demonstrate what collectively they achieve. As we have seen through networks such as Healthy Cities, the Public Health Alliance and Health For All, the groups do unite collectively, but within their own locality work on an individual basis. It is the differences in organisation at the local level and unity at national and international

level, which call for a new model of urban social movements to be developed that can incorporate this structure.

Within this thesis at the local level the Health Strategy Groups is the only group that has been defined as a local urban social movement for public health, because it adequately meets all the criteria laid down of what constitutes an urban social movement, and it has been the most successful group in terms of numbers of projects and activities it has achieved, its ability to influence the local and health authorities, and the degree and extent of participation. The other two groups studied for this thesis did not meet some of the criteria laid down by this and other authors on what constitutes an urban social movement in terms of voluntary participation, distance from political activity, mobilisation techniques,. However, although they might not be considered an urban social movement for public health in their own right, they are part of the wider new public health movement which is made up of a number of groups such as the Globe Town Health Action Area and Spitalfields Working Party who operate at a local level, but share similar ideology and guiding objectives.

This thesis could not fully enter into the broader discussion of the links between the local and global structure of movements within the time and 'length' constraints of carrying out the research. It has highlighted (using the example of the new public health) that this structure does exist, and this is perhaps an area where geographers will be able to contribute in developing and expanding the existing theory on urban social movements. There are a number of other movements which have begun to take on this global yet local organisation most notably the Green or Environmental movement. What is particularly interesting about this movement, is that like the new public health movement, the Green movement is also focussed on improving the environment within the context of present societal structures.

The new public health is improving the health of populations by concentrating on health in the context it occurs - society. This is the context in which medical geographers should also be looking at health. In order to really understand the mechanisms involved, analysis must be carried out at the local level, and although this creates difficulties in trying to generalise and define the new public health movement, the very nature of the fact that there are such differences and similarities between the local expressions actually gives the movement its definition. As we have seen from the literature on urban social movements, writers such as Castells (1983), Pickvance (1985), Dunleavy (1980) and Lowe (1986), whose research centres on urban social movements, have failed to develop a model that can adequately incorporate the new public health movement. A new model has to be developed to account for this movement which allows for the global collective action of the movement to be guided by an overall aim of improving public health, but in practice at the local level is guided by place specific objectives. Thus the key to understanding the differences and similarities of the local expressions of the new public health movement lies in an analysis of place (in terms of the physical, social and economic environment) that guides the objectives of the local components of the movement. In addition, geographers could contribute more to the literature on urban social movements in order that the value of place in shaping the organisation and structure of the movements, and as a key mobilising factor in the formation of movements, is not overlooked.

## 3. Place

Information on place was gained from two main methods of data collection within this thesis, firstly material was gathered from what respondents mentioned in the depth interviews and also from participant observation. The second method of data collection was in the form of the projective technique exercise using photographs which was developed to enhance the data collected from interviews. The main reason that the

projective technique exercise was developed was an attempt to discuss places specific to Tower Hamlets within the context of public health activities without the researcher having to describe particular areas. As stated in chapter four, a full repertory grid analysis was not undertaken or attempted due to the positivist framework that this method is derived from. However, the insights offered from personal construct theory were useful as a starting point in order to encourage the expression of personal emotion in relation to the environment as depicted in the pictures, and in particular in relation to public health in Tower Hamlets. The notion of using a construct was taken from personal construct theory but was not carried``` out in as much depth, the main idea being to use the notion of a construct to lead into discussion and to ascertain whether areas of Tower Hamlets were considered to have a worse or better environmental quality, as the interview material and participant observation data had suggested. Using the photographs was an attempt to identify the main criteria on which respondents judged the areas within the borough, again this was an adaptation from personal construct theory and repertory grid analysis.

At an individual level there are obvious differences in perceptions of place, and these relate to the individuals' personal experiences. An example that was used in this thesis was how two respondents saw a certain type of housing as unacceptable, and uninhabitable, (Figure 16), whereas another respondent perceived the same dwelling as desirable. This example clearly illustrates how 'personal' sense of place differs. These responses were in answer to the question of 'What would it be like to live in this area?'[1], which was aimed at eliciting a personal response. When respondents in the second part of this question were asked to select photographs that had relevance for their work, the photographs that were chosen were much more uniform in terms of their content. Nearly all the respondents selected photographs which contained tower blocks, or other obvious local authority, poor quality housing. Thus we can see that in terms of public health work, there is a definite framework which has influence over people's sense of place. Sense of

[1] See Appendix B, question 8(i)

place studies have always been used as a tool to understand individual's 'unique' perceptions of place, the evidence from this thesis suggests that individuals have different perceptions depending on the context; in this case there are obvious differences between relevance for their home and relevance for their work. However, the fact that the senses of place relating to the work environment were so much more homogeneous leads to the conclusion that a 'common' sense of place can be fostered, or learnt, by people who share other common ties. In this case the common ties or links lie in the fact that they belong to the same urban social movement.

Thus the relationship between place and urban social movements is two-fold. Firstly, the members of a movement need to have a strong identity and relationship with the place that they are working in. This is necessary in order to mobilise themselves, and it also determines the issues and needs that they will act upon. Secondly, a process is in operation that engenders a common sense of place for the group members, because of the relationship they have to one another and to the common aims of the group.

An analysis of sense of place also helps us to understand how the public health environment is perceived before we can assess how the new public health might change it. In general, experience of place is highly individual (Gesler 1991), although as Lynch (1960) pointed out, as individual images overlap we may see a public image, or when individuals are working closely together as a group "communities can develop an image...in which the identities of places of significance to that group are a reflection of group interests and biases" (Relph 1976, p57). However, as was demonstrated with some of the photographs in chapter seven, one person's perception of something ugly and unattractive may be acceptable to another. For this reason it is essential that public health activities are sensitive to the perceptions of the community before they condemn an environment that the inhabitants are proud of, alienating the community in the process. In chapter seven there was evidence of Lynch's theory of 'overlapping' images, in the groups' perceptions of individual neighbourhoods, and of the areas that they worked in.

In addition to being sensitive to the communities' perceptions of place, new public health activists strive for a shared sense of place within the group. From the evidence in chapter seven, it is possible to conclude that a common shared sense of place helps to bond members of the group together, and provides a clearer focus for activities. The Globe Town Health Action Area, which was operating in an artificially created neighbourhood, found that it was difficult to foster a sense of the area that they were working in, thus, there were difficulties in conceiving new activities for action. Conversely the Health Strategy Group and Spitalfields Working Party had such strong and fixed senses of place for certain areas, that they ended up concentrating their efforts in these areas with the result of ignoring others which when using objective measurements of need (such as the Jarman or Townsend indices) were similar. The evidence in this thesis suggests that it as at the neighbourhood level that the groups have developed fixed or stereotypical senses of place, which are represented in public.

One of the key conclusions that was drawn particularly from the participant observation and interviews, is that it is familiarity with place which encourages participation and in addition helps to mobilise other people to become involved with the movement by helping them find solutions to their perceived and observed needs. The research in this thesis has suggested that a reason that work is not carried out in certain areas that when ranked objectively have the same public health needs, is because there has been little or no mobilisation from those areas.

Although the local activities are the important building blocks of the overall movement, the work of the groups at the local level cannot be relied upon to be comprehensive in terms of the geographical areas that they cover. As has been demonstrated, the groups rely heavily on their sense of place (in terms of how they perceive the public health need of an area), to direct their work and activities. Although they are accurate in perceiving areas of need, they also fail to address other areas of similar

need that they do not know as well as the areas that they currently work in. This problem can be overcome by introducing new people to the groups from the more neglected areas who can help to re-negotiate the boundaries for the groups activities. It is essential that membership is widened to incorporate people from the neglected areas, and not just to start implementing extensions of the same projects in those areas, but to design new 'bespoke' projects. It is the knowledge and sense of place that the individual members of the groups have, that enables them to tailor their work specifically to the needs of the community. As members from the groups continue to foster ties and associations with particular places through their work, so their knowledge builds, and demand for more work becomes apparent, resulting in a circle of public health activity within specific communities. As Milio sums up:

> "the new public health when expressed locally might be reviewed as 'community' it binds people and builds communities " (Milio 1990 p291)

This is one of the fundamental reasons why the public health groups are more successful than the statutory authorities, because they have fostered the close ties and association with the places in which they work, and this is also one of the main mobilisation factors in creating and sustaining the new public health movement.

This geography of the new public health has concentrated on analysing the new public health in terms of its importance as an international but locally organised urban social movement. It has demonstrated the role and importance of sense of place to an understanding of the new public health, and also the role of sense of place in the structure and formation of an urban social movement. A further geography of the new public health could analyse in more detail the global significance of such a movement, and the relationship between the movement and national governments, and the effects on policy that the new public health might have over the coming decades.

## 4. Critical Reflection - methodology and constraints

This penultimate section reviews how decisions were made about what aspects of the research should be included in the final write-up, and on what basis those decisions were made. It also reflects on some of the weaknesses of the thesis, and how they might be addressed in future research, or how this author was unable to overcome them within the context of the research, and within the context of where and how the research was undertaken.

The purpose of this section as the title suggests is to critically reflect on the construction of this thesis, in terms of what was included and what was excluded, and what external and internal constraints were placed on the research. A PhD thesis is a very specific piece of research, it has limitations posed on it in terms of length, structure and composition, this is one of the main constraints that is placed on the research undertaken. In focusing on the new public health, there was a large number of interrelated issues and topics that deserved coverage, but within the limitation of the thesis, decisions had to be made on what to exclude and what to include. The empirical data on which this thesis is written, still exists in various forms from 'raw' data in the form of the cassette tapes from interview and notes taken in research diaries, as well as more processed data in the form of transcriptions and analysis of participant observation notes. Thus many of the topics excluded in this thesis could still be analysed and written in a different format. However, the purpose of this section is to reflect on why certain topics were not treated to a full discussion, and how this may have affected the final product. It should also be noted that some of the topics that were excluded were not excluded because of the constraints imposed by the designated length of the thesis, but were excluded because of constraints that arose from the context in which the research was undertaken.

A number of constraints arose from undertaking the research from a base within the Department of Public Health in Tower Hamlets Health Authority, although primarily the emphasis was on public health activities of voluntary groups. Although I was funded by the Department of Public Health, the product of the PhD research was not for them, and it was established from the beginning that they would have no claims to ownership. The exchange that they received from funding the research was the additional work that I undertook for the Department in terms of contribution to reports and liaison with the community and voluntary sector. Although to a certain extent I had autonomy about what I could write up, there were certain aspects of my research that were discouraged, one of these aspects concerns the wider debate of collectivism versus individualism within the context of health services and provision.

Soon after I registered for my PhD the initial discussion documents on the major health service reforms were published, followed by a Green Paper in 1989. Within public health in particular the Acheson report of 1988 contributed to a number of changes in the role of public health departments within the health service. Thus throughout the research period the health service has been in a state of constant change, people's futures are insecure and there are constant battles to maintain resources and current levels of provision for the populations being served, as well as maintaining a personal professional status and maintaining security amongst the many 'mergers' that are going on.

For many individuals working within the health service there are enormous tensions between the national political agenda that has been taken for the health service and their own individual professional beliefs about the delivery of care. The New Right ideology that has dominated British Politics since the mid 1970s (Desmond 1987) has encouraged the demise of the post-war Keynesian welfare state consensus, and there has been a revival of market mechanisms for public policy. Nowhere has this been more apparent than with the reforms of the health service, with the creation of internal markets and the split between 'providers' and 'purchasers' of care. At the time that the research for this

thesis was undertaken, there were many policy debates about the ensuing reforms. Public health has been particularly affected by the creation of internal markets within the health service becoming responsible for purchasing and providing services, and becoming more involved with management of resources and budgets than with the overall level of the population's health.

The New Right ideology is seeking to end collectivist policy and to dismantle citizenship rights (Green 1986), thus the groups such as those researched within this thesis do not fit into the new ideology for the health service. The participation of interest groups within the health service is encouraged at the level of 'consumer' groups. Within the market system groups are actively encouraged to debate issues of quality and provision in order to stimulate the market. However, the groups that were researched for this thesis are not consumer groups, they are actively trying to demonstrate how public health should be provided, and collectively consumed, which is in direct opposition to the free market approach. In order to explore fully the individual and collectivst tensions, I would have had to interview managers and providers of services within the health authority, this was not possible. My funding situation was precarious throughout the research period due to these very tensions, and I was actively discouraged from looking into these issues.

When I first started the research, health authority members were not allowed to actively participate in meeting of the Health Strategy Group, although they were allowed to observe. When the Tower Hamlets Health Inquiry was published in 1986, the Health Authority at the time refused to discuss the recommendations that were made as a whole. But gradually by 1989, members of the health authority entered into a discussion about the Health Inquiry, but were not supportive of all the recommendations. There was still a feeling that persisted that groups like the Health strategy Group, and Spitalfields Working Party were in opposition to the health authority. These tensions between the health authority and the community and voluntary sector can be highlighted by the following

example. During my time with the Department of Public Health I was involved, in conjunction with a number of voluntary groups, in setting up a conference on Health For All. The idea came from one of the community groups, and the purpose of the day was to explore the wide variety of activities that was going on in Tower Hamlets, that when collectively examined would demonstrate how much was being done in pursuit of the Health For All targets (at that time something that the Department of Public health had a responsibility to record). The health authority through myself and other workers from a number of departments was actively participating, but it was felt strongly by the organising committee that ownership of the day should be by the community. Both the health authority and local authority donated resources to enable the conference to happen, I was then asked by key people within the health authority, to ensure that the health authority had ownership of the event, and was told that if I was unable to achieve this then my funding would be stopped. There were a number of personal and political reasons for this decision, the point to be demonstrated is the difficulty that I had in trying to research issues that the health authority was particularly sensitive about, and explain the context for excluding a more thorough analysis of how my research fits into wider debates about individual and collective approaches to health and society.

The constraints placed on me from working within the context of the health service also led to the decision to exclude some other local issues to do with health. The two issues in particular which were not covered in this research were the campaign to save one of the two accident and emergency departments in the district, and the suspension of a local obstetrician. The suspension of the obstetrician occurred in 1985, three years before this research began, but was an incident of national significance, however, although the obstetrician had been reinstated by the time I joined the health authority there were still problems concerning the treatment of the person in question and the underlying issues that had caused the suspension had not been resolved. The campaign to save the casualty unit did occur during the period of this research. My decision to leave these two campaigns out of my research was for two main reasons. Firstly, the people within the health

authority who were directly responsible for my funding had been very involved in both these issues, which were considered to be extremely politically sensitive, and due to the precarious nature of my funding relationship I decided not to jeopardise the research I was doing by becoming involved. Secondly, and more importantly, these two issues were to do with health service provision, not public health. It was because of the tensions between particular individuals that I decided to look at public health through an analysis of voluntary groups. For similar reasons the involvement of the local community health council (CHC) is not a specific focus of the study as they are more concerned with dealing with issues relating to health services than public health and secondly although members of the CHC were involved with the groups being researched, the CHC as a whole was not directly involved in the public health activities of the groups.

I have highlighted some of the constraints placed on me from working within the context of the health service, these are in addition to the point raised earlier in this thesis in chapter one and four about the professional and managerial control that there is on the types of research that are conducted within a health service context in order to fulfil some of the expectations of managers and medical professionals in terms of more quantitative research. Other constraints and exclusion were more to do with the scope of the research and the direction of the thesis.

One of the main conclusions that this thesis draws is that the new public health as an urban social movement is made up of a number of social movements working at the local level that collectively can be taken to be a global urban social movement for pubic health. However, although this conclusion is drawn there was not a depth analysis of the new public health at the global level, other than the discussion in chapters two and five. Part of the reason for this, can be explained in that this thesis is the first step towards developing a theory about the new public health, and a case-study approach of one locality was decided as the most appropriate way to investigate the issues. It was not within the scope of this thesis to go on to theorise about the differences between the local and global

level, the research within this thesis is at an earlier stage. The evidence for outlining how the new public health is a movement at global and local level needed to be presented before analysing the significance of a movement organised in this way. The strength of this thesis is that it sets the context for further research into the new public health movement at a global level, in addition to widening the question to incorporate links to other movements operating at this level such as the environmental or green movements.

Similarly, there was little attention paid to macro policy and political issues surrounding the new public health. This again was to do with wanting to concentrate on local processes with a case study approach and although the wider political and historical issues surrounding public health are mentioned, they are not analysed in depth. However, as with the theory on urban social movements, this thesis has contributed to a further analysis by examining in depth the processes at a local level.

In addition to these more macro issues that were excluded due to the various constraints listed there was also an important micro issue that I decided against writing up. This research is primarily concerned with the construction and activities of three groups, by using participant observation as one of the main methods of data collection I was able to observe the intricate workings of the groups, especially the group dynamics. A great deal of the information collected in research diaries throughout the research period relates to group dynamics, however for a number of reasons I decided against including this analysis in my final thesis. By going into the groups dynamic theory in detail, I felt that the focus of the research was being overshadowed. This thesis is about participation in public health in order to make changes to the social, economic and political structure of health and society, the research is carried out through an analysis of the activities and membership of three groups. The group dynamics is obviously an essential part of their functioning, and this is recognised in chapters five and six, however, any further analysis of group dynamics would have taken the emphasis away from what the groups were achieving. This is also the reason that the Wendy Savage affair and the campaign to save

Mile End accident and emergency department were not discussed, as this would have involved a great deal of analysis of the group dynamics which were too politically sensitive to be written up at this time.

Secondly, I decided against going into the group dynamics analysis in depth, because there would be a number of problems in trying to respect confidentiality of the respondents. I had to work very hard to build a relationship based on trust with the different respondents, to analyse their individual actions in such depth, I believe, would have placed that trust in jeopardy. It is possible that after a period of time has elapsed some of these issues could be explored more fully, or that perhaps the research could be written up in a different way by not identifying the health district that the research was carried out in, or by disguising the groups.

Another issue that I chose not to focus on, was the role of feminism and gender within public health and the new public health movement. Rose (1993) discusses how humanistic geographers have examined place and urban social movements from a masculine point of view, by paying little attention to the role of women in the formation and mobilisation of urban social movements, and by negating the differences in men and women's experiences of place. I do recognise the importance of gender in the formation of the groups and in perceptions of place and comments are made throughout the empirical chapters. However it is important to stress that the methodology chapter highlights how feminist theory influenced my choice of research methods and me as a researcher.

This critical reflection has been included to provide further context to the study, but also to raise some issues for further research on the new public health. The final section of this chapter goes on to outline an agenda for research into the new public health.

## 5. The New Public Health Movement

In the literature that has been written on the new public health, the research involved has missed a stage in its progression. Writers such as Ashton and Seymour (1988), the Research Unit in Health and Behavioural Change (1989) and Kickbusch (1989) concentrate their attention on developing research in relation to devising healthy public policy. The purpose of looking at public health from a geographical perspective in this thesis, has been to take one step backwards in order to gain an understanding of how the new public health operates in practice, to see how and why activities are shaped in the way they are, not just to jump straight to the point of examining the new public health's impact on policy. There has to be a thorough understanding of the processes involved in the new public health before we can switch the emphasis to its outputs. Research has tended to concentrate on how the new public health movement came about through an analysis of the historical development of public health since the nineteenth century. This is a valuable starting point, and one that was necessary as part of the context for this thesis; however, a historical perspective does not provide information on what makes the new public health an urban social movement. It does not inform us as to what processes are in operation to enable new public health to sustain itself, and in what areas it is successful or unsuccessful - the processes involved in the new public health. This is linked to the similar process of using sense of place to understand how the public health environment is perceived before examining how the new public health movement can change it. As Townsend (1990) at the conference on 'Research for Healthy Cities' points out:

> "Material including environmental factors are now attracting more attention in relation to the distribution of health. Social factors remain to be assigned their due significance, health has to be understood and measured in relation to the roles people play, the social settings in which they live and work, and the relationships which they have as members of society from birth to death."

(Townsend 1990, p29)

The point being stressed is the need to be more explicit about an alternative social model for health, which examines health in an holistic manner, and that develops the theory behind the concept developed by WHO of complete physical, social and mental well being (Townsend 1990, p19). Townsend goes on to stress that "measurement depends crucially upon theoretical context". This has also been one of the basic premises of this thesis: that to understand the new public health, there has to be an in-depth analysis of the context that it occurs in, and the context of the formation of the new public health as a movement.

As mentioned in the introduction to this thesis a number of writers (Kickbusch 1990b, Tsouros 1991, Ashton and Seymour 1988) have identified the new public health as a movement, although none have analysed the new public health movement from within the context of the literature on urban social movements, and the criteria that define movements that have been suggested by writers on urban social movements. From the evidence provided in this thesis, it is apparent that the new public health is correctly perceived as a movement. The criteria or definitions laid down by writers such as Castells, Pickvance, Lowe, Dunleavy, Touraine and Hasson are all applicable to the new public health movement. A new interpretation of the main elements of an urban social movement were laid down by this author, in order to offer a more specific set of criteria then some of the broader definitions used by other authors. These broader definitions offered by some authors fitted most voluntary groups, who were not necessarily part of a wider urban social movement, and did not offer specific enough criteria on which the difference between voluntary associations and urban social movements could be distinguished. The criteria for an urban social movement advocated in this thesis are: the common aim of the members of the group (in trying to effect change); the voluntary nature of participation within the group; the shared identity of place; the importance of democracy; and the pluralism of the membership. However groups who do not fit these

criteria as urban social movements in their own right, are still able to be part of the wider urban social movement made up of a collective of groups working on public health issues.

Authors and advocates of a public health movement who have defined the new public health as a movement but without qualifying how or why the new public health is an urban social movement have in the past, been left open for criticism. In other words they have been making an assertion but without the concrete evidence to support this premise. Stevenson and Burke (1991) argue that there are many theoretical and methodological problems in health promotion and public health research which result from "partial and contradictory appropriation of the discourse of new social movements" (Stevenson and Burke 1991, p 281). But much of their argument is centred around whether health promotion as an authority organised activity can be a urban social movement. They go on to say:

> "to state the matter boldly, the movement for health promotion is not a social movement but a bureaucratic tendency; not a movement against the state but one within it." (Stevenson and Burke 1991, p283).

Their argument supports the assertions made in the introduction of this thesis that the new public health is more than just health promotion. Their assertions do not hold true for the new public health movement, as we have seen by analysing the movement in detail using a case study of Tower Hamlets, and the wider network of HFA 2000 and Healthy Cities. Although the new public health through its links to WHO has a 'bureaucratic tendency', it also has links to more 'politically' radical groups such as the Public Health Alliance and Critical Public Health. In addition at the local level of Tower Hamlets, the new public health is organised multi-sectorally, with no control from statutory authorities, just in most instances their commitment and democratic participation. Stevenson and Burke also fail to address the difference between social and protest movements - both

health promotion and the new public health movement could not be considered protest movements, which is what the writers are alluding to when they write about being "against the state". By taking the step backwards to analyse the new public health movement in detail and gain a thorough understanding of the key elements and the operational processes, it is possible to counter the arguments that were emerging questioning the status of the new public health as an urban social movement.

This thesis has brought together the need for a contextual and holistic analysis of the new public health within society with a need for a contextual and holistic analysis of health in medical geography. The scope of the thesis is such that it has only been possible to concentrate on one locality, in order to explore how the new public health operates at the local level. If medical geography takes up the challenge to look at health in the totality of society, a more complete picture of the new public health at the local level could be pieced together, offering us in turn a more complete scenario of the new public health movement. Milio outlines the agenda for research on the wider issues related to the movement:

> "to create a public health movement for a sustainably healthy world means successfully addressing three issues: widening the scope of the health problem beyond specific diseases or risks; utilising the full range of policy instruments to nurture health; and developing strategic organs and methods that can provide and deploy, monitor and assess health supporting policies." (Milio 1990 p292)

Kickbusch points to similar research needs:

> "Social activists towards a more healthy society are to be found the world over in health movements, self-help organisations, among ecologists and in groups of health professionals moving towards primary care....Our knowledge on the factors influencing health has widened into social epidemiology, self care research, health culture research and research on the interaction between the individual and

> the social and physical environment. These elements can be consciously be brought together to renew public health" (Kickbusch 1990b p382)

The agenda set by both Milio and Kickbusch is an agenda for medical geographers. In this thesis the new public health was investigated by examining the interrelationship between the elements of public health, place and urban social movements. The areas for future public health research raised by Milio, Kickbusch and other writers such as Turshen (1989) and Martin and McQueen (1989) have mapped out the path for a new geography of the new public health.

## Appendix A

In order to maintain the anonymity of the respondents who agreed to take part in the study, no names could be used, - even making up names was thought to be unsuitable because of the connotations that certain names may have for class, gender, and ethnicity. Instead each respondent has been ascribed a letter, and as much contextual information as is possible without identifying the respondent has been given. Where an age has been given, 'young' refers to under 40, 'middle aged' 40-60, and 'older' refers to over 60; class where given is defined as working or middle; ethnicity where given, is termed 'black' or 'white', as to differentiate any further gave too much indication of identity of some of the respondents. The term resident is given for those who are at present or who have at some time been a resident of Tower Hamlets. The appendix covers people who were used in both the interviews and the photograph exercises.

**A** - is a white, young woman, who belongs to more than one group

**B** - is a white, middle class, young woman who is a member of more than one group

**C** - is a white, middle class, middle aged, male, who is a member of one group. Resident.

**D** - is a black woman who is a member of one group

**E** - is a black young woman who is a member of more than one group

**F** - is a white, middle class, young woman who is a member of one group

**G** - is a working class, white, woman, who is a member of more than one group. Resident.

**H** - is a white working class male who belongs to one group. Resident.

**I** - is a young, middle class,white, male who belongs to more than one group. Resident.

**J** - is a white, middle aged, woman who belongs to more than one group. Resident.

**K** - is a white young woman, who belongs to one group. Resident.

**L** - is a young middle class, white male who is a member of one group

**M** - is a black young woman who belongs to more than one group. Resident.

**N** - is a black man who belongs to more than one group

**O** - is a black young woman, who belongs to more than one group. Resident.

**P** - is a white working class man who belongs to one group. Resident.

**Q** - is a white, young man who belongs to one group

**R** - is a white, middle aged woman, who belongs to one group. Resident.

**S** - is a white, working class, young woman who belongs to one group. resident.

**T** - is a young black woman, who belongs to more than one group

**U** - is a white middle class, middle aged man

**V** - is a white, middle class, middle aged woman. Resident.

**W** - is a white, middle class, young woman.

## Appendix B

The final interview schedule was as follows:

Using sample of 25 Photographs (10 Black and White, 15 Colour)

1. Look through the photographs and describe each one briefly.

2. Are there any differences between the black and white photographs and the colour photographs?

3. Select two photographs which are opposites for you and describe why.

4. Repeat exercise 3.

5. Find two photographs which are in between each lot of your opposites. Describe why

6. Pick out three photographs which appeal to you. Why?

7. Pick out three photographs which do not appeal to you. Why?

8. Using Photos which will be in the map exercise from original sample (less than 25):
   (i) What would it be like to live in these areas?
   (ii) Choose any of the photos which you feel have relevance to your work. Why?

9. Map Exercise. Respondents have six minutes (approximately) to place sixty photographs on the map.

## Appendix C Methodology Supplement

This appendix was written after the main body of this thesis and has been added in order to give additional information and explanation about some of the methods employed. This appendix is divided into three sections, the first section looks at the dilemmas of undertaking participant observation within the context of my research and my position based within the Department of Public Health. The second section then details how the data from the participant observation and interview material were recorded and analysed. The final section reviews how different methods have been employed to study place, and reviews these differences in the literature on sense of place, urban images and mental maps.

### 1. Participant Observation

Participant observation is, as was discussed in chapter 4 (p 90), a method which involves the researcher becoming a methodological tool, there are also varying degrees to which the researcher becomes involved in the process. For the majority of the research carried out for this thesis, I was acting as 'complete participant' within the participant observation method. This brought with it a number of complications as well as benefits, and it is important to highlight these within the context of the methodology undertaken, in addition to providing some insight in to why the thesis was constructed and written in the way that it is.

My role as complete participant was largely due to the fact that I was working from within the Department of Public Health based in Tower Hamlets Health Authority. Thus I was considered to be a Health Authority employee, although in fact I was not on the pay roll as my grant was administered through the University. However, to some of those outside of the Department of Public Health (particularly within the three groups I was

researching) I was perceived as a member of the department, to others who I had known whilst I was employed as a research assistant at the University, I was perceived as a student. The different perceptions of my position were evident in the comments people would make to me, for example people who were critical of the Department of Public Health were those who tended to view me as a student, this also demonstrates the level of trust I was able to establish with them in that they were able to be critical in front of me.

Working closely with those formally employed in public health also helped me to gain a greater understanding of the relationships involved between key people in public health in Tower Hamlets. A great deal of information about how the health authority interacted with staff from the local authority and people working in non-statutory organisations was gained from being a participant observer in meetings between the various groups, and also being able to hear comments made by staff in my Department about key personnel in other organisations, or comments about work that was being undertaken between them. This was extremely useful in gaining an insight into how activities were carried out 'informally'.

As was highlighted by some of the empirical evidence drawn on in this thesis the local and health authorities work in slightly different ways, and they in turn work differently to the local community and voluntary groups. This is partly due to the level of bureaucracy, and partly due to the individuals involved. In general the differences in the way the different statutory and voluntary groups work are accepted but rarely admired. However when there are particular clashes of personality or what is deemed to be unnecessary bureaucracy, problems can arise. In Tower Hamlets this occurred in a number of areas, and the Department of Public Health was not always respected by colleagues in the local authority or voluntary sector. From some groups there was a great deal of hostility towards the department of public health and Tower Hamlets Health Authority in general. The significance of this is that although gaining access to various organisations was made easier by my being attached to the department, in practice I also encountered some difficulties in gaining trust because of my attachment to the Health Authority. This led to

me having to make a number of decisions about what I would include in my research in order to gain support and trust from the participants of my research. As discussed in the conclusion this led to a number of constraints on my research, as I avoided researching 'politically' sensitive issues. In some cases I was actively discouraged by health authority personnel.

Trust is an extremely important element within any relationship, but is perhaps more important in a research relationship, if the researcher is to gain the material that she is after. On reflection it is apparent to me that some of the interviews that I undertook were not as successful as others due to their being a lack of trust in me by some of the respondents. Similarly a lot of information that was gained from the participant observation and interviews could not be presented in this thesis without my breaking the trust placed in me by a number of the people I worked with over the course of my research. This has the obvious affect of muting some of the analysis of key themes within the thesis around the more sensitive issues pertaining to the three research groups, particularly because I could not analyse some of the key discussions in depth or the groups dynamics. Had I not been so involved with the groups, and with particular individuals from the groups and key individuals from the health and local authority, it would have perhaps been easier to write up some of my observations. However, this was not possible without damaging some of the relationships that I had established. In the end I had to compromise the detail of my research for the trust that had been placed in me. I was explicit in saying that the research I was doing was towards my PhD, and that it would not be used by the Department of Public Health, however there were occasions when I felt that people felt unable to confide in me, in case it was taken back to the Department. Similarly some members of the groups would ask me to represent their views to the Department or arrange meetings because they felt I could have some influence.

In writing up the research for this thesis, I took the decision not to jeopardise the relationships that I had made, or relationships between other participants. Once some

distance from the research has been gained, or using different techniques and a different forum to present the work, opportunities should arise for some of the issues that were played down in this thesis to be explore more fully. However at the time of writing the thesis, and still actively participating in public health activities in Tower Hamlets this was not possible.

## 2. Practicalities of Data Analysis

The methodology chapter outlines details of how the data for the thesis were collected, this section of the appendix describes further details of how the data was recorded and analysed. It examines each of the three main forms of data collection in turn.

### Participant Observation

The main way that information from the participant observation was recorded was in a series of notebooks or research diaries. In all material was collected in 7 research diaries, each one covering approximately a 3-6 month period. The research diaries consisted of various material which can be grouped under four main headings:

- Appointments/Practical notes
- Comments/Observations
- Concepts
- Questions

The first heading covers the practicalities of research. At least half of each of the research diaries was taken up with practicalities such as lists of 'things to do' or appointments. Other practicalities concerned noting down references, notes from relevant

seminars or conference papers. This material had less use during the writing stage of the thesis than it had during the active research stage. However it was useful to have kept it in notebooks as it shows the chronological development of the research and how different events and meetings influenced my thought processes.

The second heading covers the recording of the participant observation material. In meetings with a number of people such as the main meetings of the three research groups, comments and observations were written down as they came to me. However, in meetings with one or two people, or where it was not practicable to write, comments/observations were written down retrospectively as soon as was practically possible. In general most of the entries are quite short consisting of one or two pages (most of the notebooks I used were A5), however, occasionally after particularly interesting meetings or encounters there are lengthy entries, with quite full descriptions. In addition there are also comments or observations about how I felt about particular activities or incidents. The process of transferring this raw data into the information drawn on in my thesis was done in an identical fashion to the way I analysed my interview data, this will be described fully in the next sub-section.

The heading 'Concepts' refers to a form of notation I adopted to highlight themes or links that I thought were emerging in the events that I was participating in. For example, if something came up in a meeting which was directly related to an issue I was reading about or interested in such as community participation, I would mark the comment or observation with a diamond in the margin. This was invaluable in writing up the research as I could easily spot significant information in my notebooks from the more general organisational issues and schedules.

Linked to this is the fourth heading I have used that of 'questions'. Throughout the research process, I noted any questions I had in my research diaries, and they were notated by a "?" in the margin (as with the diamonds to denote patterns this helped me to find them

easily amongst what were not always 'neatly' written research notes). These question varied from substantial research questions to more general inquiries about terminology or who particular people were. The more routine questions, once answered, were crossed through thus leaving only the major research questions outstanding in the diary. It was these remaining questions and concepts that helped to structure the thesis in the later stages of the research process, and guide the directions of the research in the earlier stages.

Although the research diaries provided quite a detailed record of the participant observation material, a significant part of the material could not be written down. This is because on reflection, my role as complete participant meant that to quite an extent I had become so involved with my research, there were many things that I took for granted. Examples of this type of 'subsumed' information include knowing people well before I started the research so therefore I did not write down detail about their position; or understanding bureaucratic administrative procedures because I had carried them out personally, so therefore I did not document them. However, although this type of knowledge was not formally recorded, it was utilised in the writing up of my research.

Interviews

In approaching the interviews there were several themes that I wanted to explore, in particular: community participation, representation, accountability and ways of working. These were themes that I had seen emerging from my participant observation and that I had collected information on in my research diaries. However once I began interviewing a number of new issues arose such as ideology, and the importance of place.

Once each interview had been completed I wrote down any comments or observations I had about the interview including comments on body language, differences of opinion, conflicting evidence between the participant observation and interview material, and my

own impressions. In addition I made a note of any 'patterns' or 'research questions' that had occurred as a result of the interview. Complete transcriptions of the interview material were then produced, and annotated for pauses, tone, and breaks in the interview.

In order to analyse the interview material and data from my participant observation I used highlighter pens of different colours to accentuate key information in the transcriptions and research diaries. Each colour was for a different theme, for example blue for issues to do with participation, green for issues to do with accountability. I then made up documents on each topic which consisted of key quotes and supplementary data from research diaries. I then went through the transcription and diaries again preparing a list of topics which did not come under the themes that I had pre-supposed. Some of these topics were used in the final write-up but in general the topics were too dispersed and individualised. The process of transcribing and analysing the data took a great deal of time, and in this thesis less than half of the information pulled out for analysis was used in the final version, in addition the material pulled out for analysis was less than two thirds of the transcribed interview material.

Projective Techniques

The projective technique exercise was undertaken in order to enhance the data collected on place from the interview material and participant observation. The reasons for doing this exercise (outlined in detail in chapter 4) can be summarised in the following way: an attempt to discuss places specific to Tower Hamlets within the context of public health activities, without the researcher having to describe particular areas. It was decided against using a full repertory grid analysis, or personal construct theory as these methods did not fit within the overall person centred methodology undertaken. An attempt was made to modify personal construct theory in terms of its use as a projective technique to provide a discussion about specific places in Tower Hamlets. The main purpose of the exercise was

to encourage the expression of personal emotion in relation to the environment as depicted in the picture and in relation to public health. As is stated in chapter 4 p103, none of the projective techniques that I had information on gave the ideal structure for investigation of place in the context of public health activities, "but the insights offered by 'personal construct theory' and 'repertory grids' were helpful". The exercise undertaken was not supposed to be with the repertory grid model, nor was it using personal constructs in the traditional way. An explanation for why using repertory grids was decided as unhelpful is contained in the footnote on p104 of chapter 4. The reason that the use of personal construct theory was modified was that personal constructs are often used to help explain particular processes occurring within the environment. The purpose of my exercise was to see if there were certain areas of Tower Hamlets that were considered to have a worse or better environmental quality as perceived by those people who were involved in the main public health activities in the borough. By using photographs it was an attempt to see on what criteria people judged the areas within the borough.

The way in which the map exercise was undertaken was described in detail in chapter 4. However, in order to provide a more comprehensive account, some more details of the process are described here. In order to select the places where the photographs were taken, a random number table was used to locate the co-ordinates for each place where the photographs should be taken. Seven maps were used, each representing one of the seven neighbourhoods of Tower Hamlets, the scale of the maps was 10cm to 500m, having such a large scale allowed the photographer to be quite specific as to where each of the photographs should be taken.

A second random number table was used to select the photographs that were to be used in each persons selection. The random number table was also used to select the sixty photographs to be used in the map exercise. Those photographs that were in the sample of 25 and in the sample of 60 for the map exercise were used for question 8 about what it would be like to live and work in these areas. At the end of the map exercise a record

sheet was filled out pertaining to which category the photograph had been placed in one of the seven neighbourhoods, "out of Tower Hamlets" or "don't know". The whole exercise was tape recorded, and the transcriptions of the map exercise were analysed in the same way as the the other interview transcriptions.

In addition to material gained from the projective technique exercise on place, the interviews also provided much of the material that was used on place within this thesis. The photographs were used in order to take me as the researcher out of the process in order to discuss the concepts relating to place and public health in more detail.

## 3. Sense of Place

Within this thesis a new way of trying to assess people's sense of place in relation to their work activities in this case public health was attempted. As has been stated in this appendix and in the main chapter on methodology, it was an attempt to use some of the 'insight' of projective techniques and personal constructs. In conjunction with the comments recorded on tape, the exercise was useful in attempting to formalise some of the theory I had developed about place and how it is perceive differently by those working in public health in Tower Hamlets in relation to their work compared to other aspects such as their own home.

In reviewing the literature on place and sense of place in chapter three and in the literature drawn on in chapters four and seven, I drew on different parts of the literature as they related to the activities I was undertaking. This part of the appendix places this in the context of other important literature relating to the sense of place studies to clarify some distinctions between sense of place, mental maps and urban images, which may cause confusion in the interpretation of the projective technique exercise. This section looks at the development of studies on perception of place from the early positivist theories of urban

images through the more behavioural approaches taken with mental maps and personal construct theory to the humanistic approaches of sense of place studies and finally the new cultural geography with its emphasis on landscape and semiotics.

## Urban Images

Linked to the structural approach of environmental perception (Downs 1970) urban images inquire into the nature of the spatial information that people use in their everyday lives. Lynch (1960) is best example of this work. Lynch defined five common elements of spatial phenomena: paths, edges, nodes, districts, and landmarks which form the structural bases of the mental images people have or urban areas. In addition he was concerned with the twin concepts of legibility and imageability and within the identity and structure of geographic space perceptions (Downs 1970). Other notable authors on this subject are Boulding (1956) and Strauss (1968)who conducted primarily sociological based inquiries into urban imagery

Urban images are important because it was felt that images underlie action, for example elite districts in a city. It has been demonstrated that different social and ethnic groups have different images of the city, "with higher status and white groups possessing more detailed and extensive images" (Eyles 1989). Urban images are the representations of the ways in which individuals define their everyday living environments. They are inner representations of the world, and they give meaning and definition to people's lives. These meanings are socially and culturally differentiated.

Downs also noted an evaluative approach based on environmental perception which looked at how people use this information in their decision making. The evaluative approach led to cognitive mapping "a construct which encompasses those cognitive processes which enable people to acquire, code, store, and recall information about the

nature of their spatial environment" (Downs and Stea 1973 p xiv). This was closely related to and later developed into the concept of mental maps.

Mental maps

Situated in Behavioural geography, this approach grew out of criticisms of the oversimplified concepts of human behaviour implicit in neo-classical and ecological models. (Bassett and Short 1989). The behavioural approach "sought to bring greater realism into model building by drawing upon sources as diverse as environmental psychology, anthropology and theories of organisational behaviour" (Bassett and Short 1989). One of the main premises behind the behavioural approach was the distinction drawn between the objective environment and the cognitive image of the environment by an individual or group. Although the term was used earlier by Wooldrige in 1956, the main author to introduce the concept of mental maps was Gould (1966). Gould argued that location decisions were arrived by taking into account perceived environmental quality. In order to investigate this Gould asked respondents to rank places according to preferences of where to live, the common elements of these rankings were analysed to produce group mental maps.

Mental maps were developed to incorporate not only reflection on what an individual knows about an environment, but also their political, social, economic and cultural values. Mental maps have taken two forms. The first form has been as images of place desirability they serve as ranked preferences, the second form relates to perceptions of spatial integration which show how individuals analyse and organise space around themselves, and how people locate themselves with respect to significant places or landmarks. In order to create a mental map cartographically a number of techniques were employed including isopleth maps based on values, cartograms (transforming topographic

space according to statistical factors) or anamorphic maps. Mental maps have mainly been used in the examination of residential desirability.

Goulds initial work and that which followed it subsequently has been criticised as being the study of spatial preferences only (Golledge 1981, Robinson 1982) and the maps themselves were criticised for becoming spatially as opposed to place orientated. However although the concept of the mental map may be a distraction, the premise on which it is based is that there are environmental images that exist for people which affect their behaviour and it is this premise that is central to the approach of behavioural geographers. By the late 1970s the behavioural approach was criticised for an over-emphasis on the individual rather than group behaviour, and more importantly was criticised for over-simplifying the relationship between cognition and behaviour. In order to overcome some of these criticisms new methods were adopted. In particular personal construct theory and repertory grids.

Personal Construct Theory and Repertory Grids* .

Personal construct theory (PCT) was developed in order to answer some of the criticisms of behavioural geography and in particular the problems with mental maps not being able to demonstrate the links between image and behaviour. Personal construct theory has been criticised for being developed as a high level of abstraction. Repertory grids have also been criticised for not relating the images to behaviour (Hudson 1980). The emphasis of the repertory grids is on the individual rather than group perceptions and so has also received similar criticisms to mental maps for this, unlike urban images which could be the products of group environmental perceptions.

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* Some of the literature on personal construct theory and repertory grids has been covered in chapter four.

Personal construct theory was developed by George Kelly form within psychology. More consistent with Kelly's personal construct theory is the analysis of the nature and type of elements and constructs, and in particular analysis of the verbal labels given to them. The projective technique exercise employed in this thesis was developed from this part of Kelly's personal construct theory. One of the biggest criticisms of PCT is that similar verbal labels used by people may have radically different meanings to each of them, this was apparent in this thesis from the labels given to 'acceptable' housing which were very dependent on people's experience of housing.

Very few studies that used PCT went on to demonstrate how image can affect behaviour in the way that Kelly felt that it did. This is partly because Kelly believed that human behaviour was motivated by a quest for knowledge (Hudson 1980). But behaviour is also motivated by the quest for satisfying need, and thus for human geographers PCT was inadequate in explaining spatial behaviour. In addition Kelly's theory presupposes that human beings can go on gaining knowledge about their environment with ever changing perceptions, and this does not take into account time, space and cost restrictions. Spencer and Blades (1986) have expressed concern that many researchers use PCT to derive environmental images rather than looking at how these images affect behaviour.

Repertory grids were developed from PCT. The technique involves an individual specifying the elements of the environment known to them and the bi-polar psychological dimensions (the personal constructs) used to differentiate these elements. The constructs are usually developed by comparing a 'triad' of elements and given verbal labels. The information can be arrange as a matrix, so that the respondent can scale the elements in terms of their scores on the constructs. Downs (1974) believed that repertory grids enabled geographers to "be humanistic, relevant and soft while maintaining an objective hard-nosed stance". However the direction that repertory grids moved in was to interpret the dimensions in terms of statistical associations, a much more positivist methodology.

Sense of Place*

Bunting and Guelke (1979) challenged the assumption that subjective environmental images can be readily and accurately measured. In a response to this and other criticisms geographers interested in researching environmental perception moved on to different techniques, theories and methodological frameworks. Sense of place studies came out of cultural and humanistic geography and was a rejection of spatial analysis and which sought to use non-positivist approaches in order to interpret the nature and meaning of the the relationship between people and place.. Ley (1981) felt that it was time to move to paying greater attention to the "semiotics of landscape, the interactions between place, identity and social context" (p254), and this was the attempt of the focus of many sense of place studies. Gold and Goodey (1983) state that in the process of researching sense of place, a wide range of literature in the arts and humanities was drawn on. Gregory 1981 has criticised this as a "mannered preoccupation with stylistic form and literary experimentation".(p2). Rowntree (1987) warns us that the "hermaneutical context of each artistic expression must be understood before specific messages about sense of place are deciphered" (p560).

However, some researchers took a different approach to researching sense of place, for example Eyles work was much more phenomenological and was concerned with the everyday contextual side of perceptual/behavioural questions (Aitken 1991). Also within more social geography has been the attempt for more interpretive accounts of the social construction of place (Ley 1985).

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* The literature on sense of place was drawn on in chapter three. This section shows where sense of place studies fit into the development of place studies in general.

In Progress in human Geography, Goodey and Gold (1987) comment that the potential impact of sense of place studies has been limited partly due to the "specific focus" and partly because of the difficulty researchers have had in extracting practical conclusions from such studies.

New directions for Place studies

Place as one of the central constituents of geographical studies is now researched from a number of different perspectives within human geography including social, economic, humanistic, cultural and behavioural approaches. Each approach is subject to criticism from writers within another; this is necessary for the development of the subject. In outlining new directions for humanistic geography Ley call for greater attention to be paid towards the 'semiotics of landscape' and the interactions between place, identity and social context. This call is directly related to a great deal of work that has been carried out in the 1980s from within cultural geography on landscapes.

Rowntree (1988) notes that recent developments in cultural geography are linking landscape and place to contemporary social theory. He notes that "this new cultural geography builds upon the Berkely School tradition with a revitalised emphasis on the landscape as a cultural construction that structures and gives meaning to the external world." (Rowntree 1988 p 580). He puts forward the argument that the symbolic qualities of landscape produce and sustain social meaning, and this has led to the emphasis on the metaphor of landscape as text.

Aitken (1991) in an article in Progress in Human geography has categorised contemporary perceptual and behavioural geography into four categories:

- spatial cognition and human behaviour
- ecological dimensions of person-environment relations
- landscape perception and experience

- comparative research involving social and cultural groups

He goes on to say that contemporary theory development in behavioural geography relates to "person-environment dynamics which reflexively account for both spatial behaviour (the rules that govern decision-making) and behaviour in space (the contexts and constraints on behaviour)"(p181). He outlines a number of new approaches to the study of place including Environmental disposition theory ; locus of control theories and spatial schema.

There have been a number of different approaches taken to elicit how perception of the environment affects peoples behaviour. In this thesis a new method was attempted borrowing heavily on PCT and sense of place studies to see how perception of place affected the way that groups carried out public health activities, and how place was a key element of the new public health movement. As was stated in the conclusion to this thesis, place is a central element to geographical inquiry and it is important that geographers from a variety of different approaches continue to develop methodologies for assessing the relationship between place and it's affect on people's behaviour.

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